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EMPLOYEE BENEFITS OVERVIEW

The City is pleased to provide you with an extensive benefits program. It includes insurance programs and other health, financial, and professional benefits. These benefit programs are listed below and described in this handbook. Complete details on each individual benefit plan can be found in each insurance provider's Evidence of Coverage (EOC), Summary Plan Description (SPD), brochure, policy certificate, or contract that applies to each specific benefit. The written policy, plan, or contract must be consulted to determine the terms and conditions of coverage for each specific benefit plan.

The benefits described in this handbook are applicable to full-time and part-time benefited employees, unless otherwise noted. For more information related to applicable benefits, for non-management employees please refer to your Memorandum of Agreement (MOA), which is the contract with your bargaining unit (union). For management employees, please refer to the Benefits & Compensation summary applicable to your classification. If there are any differences in the information contained in this handbook and the applicable MOA or Compensation summary, the MOA or Compensation summary supersedes. If you are unclear about whether or not a particular benefit applies to you, please contact Human Resources at (408) 535-1285 or the Office of Employee Relations at (408) 535-8150.

HEALTH INSURANCE

Five health plan choices are available:

- Kaiser Permanente*
- Blue Shield (HMO)*
- Blue Shield (Point-of-Service)*
- Blue Shield (PPO)*
- Health-In-Lieu (available if you have other alternate health insurance)

DENTAL INSURANCE

Three dental plan choices are available:

- Delta Dental Plan (PPO)*
- DeltaCare USA Plan (HMO)*
- Dental-In-Lieu (available if you have other alternate dental insurance)

VISION CARE INSURANCE

Two voluntary vision plan choices are available:

- EyeMed Vision Care Plan*
- Vision Service Plan (VSP)*

** The City's Health, Dental, and Vision plan premiums are deducted from your paycheck pre-tax (Exception: A pro-rated portion of the monthly health premium which is attributable to domestic partners is considered taxable imputed income by the IRS. Please refer to the City's Affidavit of Domestic Partnership form for a more complete description of this tax issue.).*

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The City's Employee Assistance Program (EAP) offered through Managed Health Network has been established to offer free, confidential counseling to benefited employees and their dependents. Services cover a wide range of personal issues including marital, family, interpersonal, emotional, and drug abuse issues. In addition, a number of life management services are available to help you with child & elder care, legal, financial, credit, IRS, and retirement issues.

FLEXIBLE SPENDING ACCOUNTS (FSA's)

These pre-tax programs, administered by New Liberty, are convenient ways for City employees to apply pre-tax money toward unreimbursed medical or dependent care expenses.

Medical Reimbursement Account (MRA) – This program is designed to help you pay for healthcare expenses that are not covered by your health plan, dental plan, etc.

Dependent Care Assistance Program (DCAP) – this program is designed to help you pay for the costs of caring for your dependents while you work.

By using a Medical Reimbursement Account (MRA) or the Dependent Care Assistance Program (DCAP), your out-of-pocket expenses can be paid from a trust account funded with pre-tax deductions from your paycheck. This reduces your taxable income so you will pay less in taxes and have more money to spend and save.

LIFE INSURANCE

Basic, Supplemental, and Dependent life insurance coverage, including accidental death & dismemberment coverage (AD&D), is provided through the City's group policy with The Standard Insurance Company.

LONG TERM DISABILITY (LTD) INSURANCE

Optional long-term disability (LTD) insurance is provided through the City's group policy with The Standard Insurance Company.

Employees should note that the City does not contribute to State Disability Insurance (SDI). City of San Jose employees are not covered under California State Disability Insurance programs. The City's LTD insurance policy covers employees up to two-thirds of their gross monthly salary if they become unable to work due to a work or non-work related illness or disability. This coverage is in-lieu of SDI and is 100% employee-paid.

PERSONAL ACCIDENT INSURANCE

This optional benefit, provided through CIGNA Group Insurance, provides additional single and family coverage for accidental death and dismemberment (AD&D) in addition to the AD&D Coverage provided under the City's life insurance group policy.

LONG TERM CARE (LTC) INSURANCE

Optional long term care insurance is provided through Prudential Insurance Company of America. This insurance covers expenses related to nursing home care, residential care facility care, and community and home-based care. It is designed to help alleviate the financial burdens of participants who suffer the need to utilize such services. All benefited employees and their spouses, domestic partners, parents, parents-in-law, grandparents, or grandparents-in-law are eligible to apply under the City's group policy.

DEFERRED COMPENSATION PLAN

This pre-tax program is a convenient way for City employees to save money for retirement. Money is deducted from your payroll check before taxes are taken out (thus reducing your taxable income) and is invested in available plan options selected by you. This plan was established under Section 457 of the IRS code. The plan provider is ING Financial Advisors.

OTHER CITY BENEFITS AND PROGRAMS

- **Paid and Unpaid Absence Benefits**
- **Workers' Compensation Benefits**
- **Employee Development Programs**
- **Alternative Work Schedules**
- **Commute Assistance Program**
- **Personal Banking Services**

CITY OF SAN JOSE
CAPITAL OF SILICON VALLEY

Memorandum

TO: All Employees **FROM: Human Resources, Employee Benefits**

SUBJECT: PRIVACY NOTICE EFFECTIVE APRIL 14, 2003 REVISED MARCH 19, 2004 **DATE: March 19, 2004**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The City of San Jose is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your Protected Health Information (PHI) and to provide you with this notice of our privacy practices and legal duties. The City is required to abide by the terms of this notice. The City reserves the right to change the terms of this notice and to make any new provisions effective to all of the PHI that we maintain about you. If we revise this notice, we will provide you with a revised notice within sixty (60) days.

PROTECTED HEALTH INFORMATION

PHI includes all individually identifiable health information transmitted or maintained by the City. PHI includes, but is not limited to,

- Your name
- Social Security number / member ID
- Demographic information (such as gender and date of birth)

PERMISSIBLE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may use and disclose your PHI for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization.

Health Care Operations – The City may use or disclose PHI to administer benefits and as necessary to provide coverage and services to you. Health Care Operations include such activities as:

Customer service and resolution of complaints
Activities relating to creating or renewing insurance contracts
Enrollment information

Health Care Payment - The City may use or disclose PHI in order to pay for your covered health expenses such as making payments to other parties, including a health plan or provider.

Treatment – The City may use or disclose your PHI to determine eligibility for services.

Disclosure to Others – The City may also disclose PHI to others under a variety of circumstances when:

- Required by federal, state or local law
- Soliciting premium bids from other plans
- Required by court actions or law enforcement purposes, or
- Complying with laws related to worker's compensation

YOUR RIGHTS REGARDING YOUR P.H.I.

You have a right to know how the City may use or disclose your PHI. This notice informs you of those uses and disclosures. You have the right to make certain requests, **in writing**, to the City's Privacy Officer (listed at the end of this document) regarding your PHI. You may:

Review and obtain a copy of your PHI. A fee may be charged for producing and mailing your requested information, if applicable.

Request to amend your PHI if you believe that information is incomplete or inaccurate. If your request is denied, we will notify you in writing. You have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

Request that the City restrict certain uses and disclosures of your PHI. However, the City is not required to agree to your request.

Request to receive an accounting of certain disclosures of your PHI.

Request to receive communications in a certain way or at a certain location (e.g. a designated mail or e-mail address or phone number).

Request a paper copy of this notice at any time, even if you received this notice previously.

Authorization to Use or Disclose Health Information – All other uses or disclosures of your PHI will be made only with your written permission, and you may revoke that permission in writing at any time.

Copy of Privacy Notice – You have the right to get a copy of this notice by e-mail. A copy of this Privacy Notice is also posted on the City's Intranet site under Human Resources/Benefits/Privacy Notice.

Complaints – If you believe that your privacy rights have been violated, you may submit a written complaint (using the Health Information Privacy Complaint form posted on the City's Intranet site under Human Resources, Benefits) to the City's Privacy Officer: Jay Castellano, Privacy Officer, City of San José, Human Resources, 200 E. Santa Clara St., 2nd Floor Wing, San Jose, CA 95113.

You may also file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services, 50 United Nations Plaza – Room 322, San Francisco, CA 94102. You will not be retaliated against for filing a complaint.

Contact us – If you have questions about this notice or your PHI, contact Employee Benefits at 408-535-1285.

ENROLLMENT & DEPENDENT ELIGIBILITY

It is important for employees to recognize their responsibilities for benefit plan enrollment. The City makes the benefit programs available, but employees must enroll to receive coverage for themselves and eligible family members.

New Enrollment Time Constraints

Many of the City's benefits have a 30-day window of opportunity in which employees may enroll and/or be guaranteed coverage. For these plans and policies, an employee must enroll or apply within the first 30 days of employment or benefits eligibility. Otherwise, an employee may be required to wait for the City's annual open enrollment period in November to enroll, or may lose an opportunity for guaranteed coverage (some insurance policies require medical underwriting information for late applications). These limitations usually apply to new dependents as well.

Default Enrollment

Health & Dental – If an employee does not actively enroll in one of the City's Health or Dental plan options within the 30-day time limit, he/she will be enrolled by default in the Kaiser health plan and DeltaCare HMO dental plan (full-time employees only). Dependents will not be enrolled. Part-time benefited employees will have health and dental coverage waived. Employees may not change health or dental plan elections, nor enroll any eligible dependents until the next open enrollment period in November. Open Enrollment changes will become effective January 1 of the following year.

EAP & Basic Life Insurance – Benefited employees will be automatically enrolled in the Employee Assistance Program and for Basic Life Insurance coverage when they become eligible for these benefits. Eligible employees must waive these benefits in order to forego default enrollment. These benefits are 100% City-paid.

Eligible Dependents

For most of the City's benefit plans, dependents are defined as the employee's spouse, domestic partner, and unmarried children (including adopted children, guardianships, stepchildren, and children of your domestic partner). Unmarried child dependents under the age of 19 are automatically eligible for benefits as the employee's dependents; however, children between 19 and 24 years of age may qualify as dependents only if they are full-time students. Grandchildren are not considered eligible dependents unless the employee can furnish proof of legal guardianship.

Child dependents, age 19 and older, who are totally disabled, are eligible for benefits if they are incapable of self-sustaining employment because of mental retardation or physical disability that occurred prior to reaching age 19, and are chiefly dependent upon the employee for support and maintenance. In order to continue benefits coverage for a disabled child over age 19, an employee must contact his/her health care provider and follow their procedure for approving a dependent's disabled status. Proof of continuing disability and dependency may be required by the health plan, but not more frequently than once per plan year.

New Dependents

If an employee gets married, has a child, adopts a child, or becomes legal guardian of a child during his/her City employment, he/she should review current benefit enrollments immediately. **An employee must enroll new dependents within 30 days from the date of marriage, domestic partnership, birth, or other change in status** in order to make mid-year plan changes.

To enroll a new dependent, submit a copy of the marriage certificate (for spouse dependent), Affidavit of Domestic Partnership or State Certificate (for domestic partner dependent) and/or a birth certificate (for child dependents) to Employee Benefits (City Hall Wing, 2nd Floor, Human Resources, 535-1285) along with the appropriate benefit enrollment forms.

An employee will be required to produce birth certificates or adoption papers to add dependent children and a marriage certificate to add a spouse, within the initial 30 days of hire or benefits eligibility. If the marriage certificate or children's birth certificates are not immediately available, an employee may request a 30-day extension by completing a *Request to Provide Dependent Coverage* form within that initial 30 days. An employee may then submit the required documents as soon as they become available. Failure to provide required documents within the 30-day extension period may result in disqualification of the employee's dependents.

The *Request to Provide Dependent Coverage* form is available in Human Resources (City Hall Wing, 2nd Floor, 535-1285) or on the department's intranet site: www.csj.gov.

Domestic Partners

The City of San José recognizes two levels of Domestic Partnerships:

- Unmarried same-sex or opposite-sex partnerships meeting the criteria of domestic partnership as defined by the State of California or as indicated on the City of San José Affidavit of Domestic Partnership. Benefit eligibility for this Domestic Partner relationship is explained in the paragraph on "***Domestic Partner Benefits***" below.
- Same-sex marriages certified by other jurisdictions for benefits purposes. Benefit eligibility for this relationship is explained in the paragraph on "***Same-Sex Marriage***" below.

Domestic Partner Benefits - Domestic Partners, and/or children of a domestic partner, may be added within 30 days of the beginning of a domestic partnership or state registration, during Open Enrollment or within the first 30 days of an employee's date of hire or benefits eligibility. In order to enroll a domestic partner and/or children of a domestic partner, the employee and his/her partner must complete and return an *Affidavit of Domestic Partnership* or provide a Certificate of Domestic Partnership issued by the State of California to Employee Benefits (City Hall Wing, 2nd Floor, 535-1285) along with the appropriate benefit enrollment forms.

Domestic Partner Imputed Income Tax - A pro-rated portion of the monthly health premium which is attributable to domestic partners is considered taxable imputed income by the IRS. Please refer to the City's *Affidavit of Domestic Partnership* form for a more complete description of this tax issue.

The *Affidavit of Domestic Partnership* and other forms are available in Human Resources (City Hall Wing, 2nd Floor, 535-1285) or on the department's intranet site: www.csj.gov.

Same-Sex Marriage Benefits – The City of San José recognizes same-sex marriages certified by other jurisdictions for benefits purposes. Employees in a same-sex marriage can enroll their new spouse, and children of their new spouse, under their benefit plans within the first 30 days of marriage. Because the Federal Government does not recognize same sex marriages, employees will be subject to the Domestic Partner Imputed Income Tax as described above.

Annual Open Enrollment Period

Open enrollment is held every year in November. At that time, employees may change health, dental, or vision plan providers, add eligible dependents to their benefit plans, provide status verifications for over-age FT students, and enroll in the City's pre-tax MRA and DCAP accounts for the following calendar year. All plan changes made during open enrollment become effective on January 1 of the following year.

If an employee did not enroll new dependents in health, dental, or vision care insurance plans within 30 days of a qualifying event (marriage, birth, adoption, or guardianship), he/she may enroll them during the open enrollment period.

Annual Student Verification Period

Employees with dependents age 19-23 who are full time students (i.e. enrolled in 12 or more semester/quarter units in an accredited college or university, or enrolled in a technical, trade or occupational school on a full-time basis as defined by the school) must provide evidence of full time status for the fall or spring term to continue carrying these dependents under their benefit plans. Verifications must be provided by the last day of open enrollment each year in order to maintain coverage in the following calendar year. Dependent students without verification will remain covered until the end of the current calendar year and dropped effective January 1 of the following year.

Health, Dental, and Vision coverage for child dependents turning 19 will be carried through to the end of the calendar year in which they turn 19. Child dependents turning 24 will only be carried through the end of the month in which they turn 24, after which coverage will be terminated (see the *COBRA Coverage* section of this handbook for benefit continuation rights).

Beneficiary Designations

Many benefit programs have survivorship or beneficiary clauses, and employees will be asked to designate beneficiaries by name and by Social Security number during their initial enrollment.

An employee should always review his/her dependent coverage and beneficiary designations soon after any major life change (marriage, divorce, birth or death in the family). Beneficiary changes can be made at any time by submitting a new *Beneficiary Designation* form to Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285).

PREMIUM CONTRIBUTIONS

Because insurance premium rates change often, they are not included in this guide. An employee can obtain information about rates (premium costs) and regular contributions at any time by picking up Health, Dental, or Vision rate sheets in Human Resources (City Hall Wing, 2nd Floor, 535-1285). Rate information is also available on Human Resources' Intranet site: www.csj.gov.

The City contributes to a number of benefits including Health, Dental, Vision, Employee Assistance Program (EAP), and Life Insurance. The contribution level for these benefits is subject to each bargaining unit's Memorandum of Agreement (MOA) or Benefit and Compensation Summary. An employee should refer to his/her MOA or Benefit and Compensation Summary for specific cost sharing arrangements.

Generally speaking, the percentage of the Health and Dental plan premiums the City pays for an employee is based on his/her Standard Hours (the number of hours an employee is regularly scheduled to work each week). If an employee holds a benefited position, the City will pay the portion of health and dental insurance premiums shown below:

Standard Hours	Amount City Will Pay
Full-Time: 40 hours/week	Based on MOA or Benefit and Compensation Summary
Part-Time: 30–34 hours/week	City pays 75% of its FT contribution
Part-Time: 25–29 hours/week	City pays 62.5% of its FT contribution
Part-Time: 20–24 hours/week	City pays 50% of its FT contribution

The City's contributions for other benefits may vary. Please consult the applicable union's Memorandum of Agreement (MOA) or Benefit and Compensation Summary for cost sharing information. Current rate information is available from Employee Benefits (City Hall Wing, 2nd Floor, 535-1285).

HEALTH INSURANCE

The City of San Jose currently offers a choice of four health insurance plans: Kaiser, Blue Shield HMO, Blue Shield POS and Blue Shield PPO. A Health-in-Lieu plan is available for employees with alternate group health coverage. A brief summary of each health plan is presented here. Plan information and rate sheets are available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285) or on the department's intranet site: www.csj.gov.

Eligibility

All full-time and part-time benefited employees may enroll themselves and their eligible dependents in one of five City health plans.

Cost

The employee's contribution and the City's contribution are subject to change each year in January in accordance with contract renewals. The percentage that employees pay of the entire monthly premium is determined by the applicable Memorandum of Agreement (MOA) or Benefit and Compensation Summary. Information on current premium rates is available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285). Please contact the Office of Employee Relations (City Hall Wing, 2nd Floor, 535-8150) for more information regarding the City's cost sharing arrangement.

Pre-Tax Premiums

The four health insurance plans are pre-tax benefits. This means employee premiums are paid before withholding taxes are taken from the paycheck. Consequently, health insurance premiums are not subject to state or federal taxes (please refer to the *Affidavit of Domestic Partnership* form for more information regarding exceptions to this rule).

How to Enroll

Employee Benefits provides a detailed plan comparison and provider information packets for each health insurance plan which describes their respective services. To select a health plan, please carefully read these materials. Employees have two options for enrollment:

Enroll on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required except for the *Affidavit of Domestic Partnership* if adding a domestic partner and/or proof of alternate coverage if enrolling in the Health In-Lieu plan.

Complete and return the City's *Health, Dental, & Vision Enrollment/Change Form* to Employee Benefits within the first thirty (30) days of the date of hire/benefits eligibility. A marriage certificate, *Affidavit of Domestic Partnership*, or *Request to Add Dependents* form will be required if adding a spouse, domestic partner, or child dependent(s).

Please Note: To enroll in one of the City's health insurance plans, an employee **must** live or work in that plan's designated Service Area. If the employee and/or dependents live outside of the Service Area for a specific plan, they will need to travel into the service area to access most services besides emergency services. See Blue Shield's PPO Health Plan later in this section.

Default Enrollment

If an employee does not enroll on-line or turn in the *Health, Dental, & Vision Enrollment/Change Form* within the first thirty (30) days of employment, he/she will be enrolled in the Kaiser Health Plan (unless you complete a *Request to Waive Insurance* form available in Human Resources). Dependents will not be enrolled. The employee will have to wait for the annual open enrollment period in November to change to another plan or to enroll dependents. Any change made at open enrollment will not take effect until January 1 of the following year.

When Does Coverage Begin?

An employee and his/her eligible dependents may use their selected health plan starting on the first day of the month following the date of enrollment. The employee will be given the date on which coverage takes effect during on-line enrollment or when Employee Benefits receives the completed enrollment form.

Coordination of Benefits

If an employee or his/her dependents are entitled to health benefits under more than one health plan, the employee should consult his/her respective plans to inquire about Coordination of Benefits. Sometimes one plan will pay a percentage of the cost not covered by another plan. Benefits are usually calculated so that the total payments by all plans involved will not be greater than the total cost of the covered services received.

Women's Health and Cancer Rights Act of 1998

The employee's health plan, as required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). For more information, please consult the health plan's *Evidence of Coverage*.

Health Insurance Claims Complaint/Appeal Procedures

The insurer is responsible for making the final determinations for benefits described in this handbook. To appeal the denial of any insurance claim, write to the health insurance company within sixty (60) days of the denial.

AFTER you have contacted your health insurance company to file an appeal and utilize the plan's grievance process, you may file a complaint against your health plan with the California Department of Managed Health Care (DMHC). The DMHC requires that your health plan provider advise their members of the following:

The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number (1-800-400-0815) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)) to contact the department. The department's Internet website (http://www.dmhc.ca.gov) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

When Coverage Terminates

Health coverage for you or your dependents will end on the last day of the month in which benefits eligibility or enrollment terminates. Continuation of coverage may be available. Refer to the *COBRA Coverage* section of this document for more information about Health, Dental, Vision, MRA or EAP benefits continuation for you and your qualified dependents.

HEALTH PLAN OPTIONS

KAISER PERMANENTE OF NORTHERN CALIFORNIA (GROUP # 887)

Kaiser is a prepaid group practice health maintenance organization that provides direct services only through Kaiser Foundation hospitals, medical offices, and physicians. Kaiser is not considered an HMO, but they do provide managed care. Each Kaiser member is encouraged to choose his or her personal physician from a list of available staff.

Summary Benefit Information

There is no annual deductible. Please refer to the applicable MOA or Benefit and Compensation Summary for current co-pay information for office visits and prescriptions. Prescriptions are covered at Kaiser Pharmacies only and are subject to a managed formulary.

Employees must live or work in the Kaiser Service Area to enroll. Please contact Kaiser's Customer Service Center to confirm that you are currently living in a Kaiser Service Area.

Kaiser will send new enrollees a member card within 7-10 business days after enrollment. Please cite your name, social security number, and the City's group number (887) when trying to access coverage prior to receiving your membership card.

Contact Kaiser Permanente

Kaiser's Customer Service Center (1-800-464-4000) can assist with questions regarding claims, eligibility, usage, and network. Kaiser also provides member-specific information on-line, including provider lists and locations, through their Internet website.

Contact Kaiser by phone:	1-800-464-4000
Or visit their web site:	http://my.kp.org/ca/csjemployees/

BLUE SHIELD OF CALIFORNIA HMO PLAN
(GROUP #H11186)

Blue Shield offers a health maintenance organization (HMO) plan for employees who live or work within Blue Shield's available Service Areas. All enrollees in the Blue Shield HMO plan must select a Primary Care Physician (PCP) from within the Blue Shield HMO network.

Summary Benefit Information

Blue Shield HMO is a prepaid direct service health insurance plan that provides services from contracting medical groups and hospitals in California.

All services must be accessed through Blue Shield HMO participating providers. All enrollees must select a Primary Care Physician (PCP). Different family members may choose different PCPs. All specialist services (except OB/GYN) require referral by the designated PCP. A member's OB/GYN must be in the same medical group as their PCP. A member may self-refer to a specialist within their PCP's medical group for a consultation visit for a $30 co-pay. All hospitalizations require prior authorization by Blue Shield.

There is no annual deductible. Please refer to the applicable MOA or Benefit and Compensation Summary for current co-pay information for office visits and prescriptions. Prescriptions are subject to a managed formulary.

An employee must live or work in a Blue Shield HMO Service Area to enroll. Please contact Blue Shield's Customer Service Center to confirm that you live in a Blue Shield HMO Service Area.

Blue Shield will send new enrollees a member card within 7-10 business days after enrollment. Please cite your name, social security number, and the City's group number (H11186) when trying to access coverage prior to receiving your membership card.

Contact Blue Shield

Blue Shield's Customer Service Center (1-800-872-3941) can assist with questions regarding eligibility, usage, and network. Members may also find personalized information by logging on to Blue Shield's website. If you have already enrolled in Blue Shield, a pre-set User ID and Password will be available within two weeks of your initial effective date of coverage. Log-in instructions are provided within the site.

Contact Blue Shield by phone:	1-800-872-3941
Or visit their web site:	www.blueshieldca.com

BLUE SHIELD OF CALIFORNIA POINT-OF-SERVICE (POS) PLAN (GROUP # MH0161)

Blue Shield offers a 3-tiered Point-Of-Service (POS) plan for employees who live or work within Blue Shield's available Service Areas. All enrollees in the POS plan must select a Primary Care Physician (PCP) from within the Blue Shield HMO network (Tier 1); however, coverage is available outside the HMO network as well.

Summary Benefit Information

HMO (Tier 1) – This tier offers the maximum coverage under this plan at minimum cost. All services are coordinated through the member's PCP (in the Blue Shield HMO network). Co-pays usually amount to $5 for office visits and services. No deductibles apply when accessing services through this tier. Preventative services must be accessed through this tier for coverage.

PPO (Tier 2) – This tier provides medically necessary services at discounted rates from participating Blue Shield preferred providers (PPO network physicians). Services must be accessed through the Blue Shield PPO network. Members are responsible for Tier 2 deductibles and co-pays. Co-pays typically include $10 co-payments for office visits and outpatient services and 10% co-payments for hospital benefits. Preventative services are not covered under this tier.

Out-of-Network (Tier 3) – This tier allows plan members to access services through any physician or hospital outside the HMO and PPO networks. Tier 3 deductibles and co-payments apply. Blue Shield will cover up to 70% of their allowable amounts for services. Members are responsible for 30% of the Blue Shield allowable amounts in addition to any uncovered balance billing if applicable. Preventative services are not covered under this tier.

Prescriptions – $5 co-pay for generics or $10 co-pay for name brands. Prescriptions are available at Blue Shield member pharmacies and subject to a closed formulary. Drugs not listed on the formulary are not covered.

Deductibles – Under tiers 2 and 3, a $100 annual deductible applies for each participant per year ($200 maximum deductible per family per year).

Service Areas – You must live or work in a Blue Shield HMO Service Area to enroll. Please contact Blue Shield's Customer Service Center to confirm that you live in a Blue Shield HMO Service Area.

Blue Shield will send new enrollees a member card within 7-10 business days after enrollment. Please cite your name, social security number, and the City's group number (MH0161) when accessing coverage prior to receiving your membership card.

Contact Blue Shield of California

Blue Shield Customer Service (1-800-872-3941) can assist with questions regarding claims, eligibility, and network. Members may also find personalized information by logging on to Blue Shield's website. If you have already enrolled in Blue Shield, a pre-set User ID and Password will be available within two weeks of your initial effective date of coverage. Log-in instructions are provided within the site.

Contact Blue Shield by phone: 1-800-872-3941

Or visit their web site: www.blueshieldca.com

BLUE SHIELD OF CALIFORNIA PPO PLAN
(GROUP # 975567)

The PPO plan was designed for employees or covered dependents that live outside of the designed health plan Service Areas; however, any employee is eligible to enroll. Rates for the Blue Shield PPO plan are the same as the POS plan rates.

No primary care physician referrals are required. Services may be accessed directly through either Blue Shield's Preferred Provider Organization (PPO) network of participating physicians or facilities, or out-of-network altogether.

Please note that some services are not covered when accessed through non-Blue Shield participating physicians or facilities. Please consult the Evidence of Coverage or contact Blue Shield to confirm coverage for out-of-network services.

Summary Benefit Information

- PPO Benefits

  $100 Deductible per year ($200 max. deductible per family per year)
  $10 Office Visit Co-pay
  10% Co-pays for most services (based on Blue Shield *Allowable Amount*)

- Out-of-Network (OON) Benefits

  $100 Deductible per year ($200 max. deductible per family per year)
  Co-pay = 30% of Blue Shield's *Allowable Amount*. Charges above and beyond the *Allowable Amount* are the participant's responsibility.
  Preventive & Family Planning services not covered out-of-network

- Annual Co-pay Maximum – $2,000 Calendar Year Co-pay maximum per person (PPO & OON)

Prescriptions – $5 co-pay for generics or a $10 co-pay for name brands. Prescriptions are available at Blue Shield member pharmacies and subject to a closed formulary. Non-formulary drugs have a $25 co-pay.

The PPO plan generally pays 90% of the cost for services accessed through Blue Shield PPO doctors or hospitals. If using the Out-of-Network component of the PPO plan, the plan will pay 70% of Blue Shield's allowable amount for services received by a non-PPO doctor or hospital (balance billing may apply).

More detailed plan information is available upon request from Employee Benefits, 535-1285.

Contact Blue Shield of California

Blue Shield's Customer Service Center (1-800-872-3941) can assist with questions regarding claims, eligibility, usage, and network. Members may also find personalized information by logging on to Blue Shield's website. If you have already enrolled in Blue Shield, a pre-set User ID and Password will be available within two weeks of your initial effective date of coverage. Log-in instructions are provided within the site.

Contact Blue Shield by phone: 1-800-872-3941

Or visit their web site: www.blueshieldca.com

HEALTH IN-LIEU PLAN

The City of San Jose's Health In-Lieu plan provides eligible employees a cash incentive to forego coverage under one of the City's available health plans when employees can furnish proof of alternate group health coverage.

Eligibility

Full-time and Reduced Work Week (35+ hours per week) employees who have alternate health insurance coverage through another group health plan may participate in the Health In-Lieu plan, or may choose health coverage under one of the three health plans described above.

In-Lieu Payments

Participants in the Health In-Lieu plan receive a cash payment of 50% of the City's contribution to the cost of health insurance, in-lieu of coverage. Payments appear on each paycheck; federal and state taxes are withheld on each payment. Health In-Lieu payment amounts are available on the *Health and Dental Bi-Weekly Rates* sheet available in Human Resources (City Hall Wing, 2nd Floor, 535-1285) and on the department's intranet site: www.csj.gov.

How to Enroll

Employees have two options for enrollment:

Enroll on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required except for proof of alternate group coverage, which can be submitted within two weeks of enrollment.

Complete and return the City's *Health, Dental, & Vision Enrollment/Change Form* and check off 'Health In-Lieu' as your choice. Return this form to Employee Benefits within the first thirty (30) days of your date of hire/benefits eligibility. Evidence of acceptable alternate health coverage MUST be provided at the time of enrollment. Re-enrollment is not necessary; payments will continue from one year to the next.

Enrollment Period

To participate in the Health In-Lieu plan, an employee must enroll within thirty (30) days of employment or benefits eligibility, or during the open enrollment period in November. Employees may apply for Health In-Lieu during the year only if they become eligible due to a Change in Family Status, and they must apply within 30 days of the date of that change. A Change in Family Status is defined as follows:

Change in marital status – marriage, divorce, or legal separation
Change in dependent status – birth, adoption, legal guardianship, or death

Change in work status (either employee or employee's spouse) – termination of employment, commencement of employment, or change between part-time and full-time employment

If an employee decides to enroll in the Health In-Lieu plan after the first 30 days of employment, or if he/she misses the 30-day time limit after a Change in Family Status, he/she must wait for the next open enrollment period.

Voluntary Cancellation

Employees who participate in the Health In-Lieu plan **may cancel** their participation and enroll in one of the available health insurance plans **during open enrollment only**. Cancellation will become effective with the first pay period of the following calendar year.

Employees may be allowed to make mid-year health plan enrollment changes (outside of Open Enrollment) only if they have a Change in Family Status (see details above under "Enrollment Period".) Contact Employee Benefits within 30 days of such family status changes to inquire about changing plan enrollments.

Mandatory Cancellation

If an employee enrolls in the Health In-Lieu plan and alternate coverage is lost prior to the next open enrollment period, the employee **must** notify Employee Benefits immediately. Upon receipt of documentation that coverage has been lost (from the providing employer or group insurer) an employee may enroll in any one of the four City health insurance plans.

Excess In-Lieu Payments Received

If an employee cancels his/her Health In-Lieu plan and enrolls in an available health insurance plan due to loss of alternate health coverage, the City's policy is to make coverage in the health plan effective the date the employee's alternate coverage is lost. EMPLOYEES ARE RESPONSIBLE FOR REPAYMENT OF ANY EXCESS HEALTH IN-LIEU PAYMENTS HE/SHE MAY HAVE RECEIVED. EMPLOYEES ARE ALSO RESPONSIBLE FOR PAYING THE EMPLOYEE PORTION OF PREMIUMS NECESSARY TO BEGIN THE CITY HEALTH PLAN COVERAGE FOLLOWING CESSATION OF HIS/HER OTHER HEALTH COVERAGE.

DENTAL INSURANCE

The City offers a choice of two dental insurance plans: the Delta Dental PPO Plan of California and the DeltaCare USA HMO dental plan. A Dental-in-Lieu Plan is available for employees who have alternate coverage through another group dental plan. Plan information and rate sheets are available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285) or on the department's intranet site: www.csj.gov.

Eligibility

All full-time and part-time benefited employees may enroll themselves and their eligible dependents in one of three City dental plans.

Cost

The employee contribution and the City's contribution are subject to change each year in July in accordance with contract renewals. The percentage that the employee pays of the entire monthly premium is determined by his/her Memorandum of Agreement (MOA) or Benefit and Compensation Summary. Information on current premium rates is available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285). Please contact the Office of Employee Relations (City Hall Wing, 2nd Floor, 535-8150) for more information regarding the City's cost sharing arrangement.

Pre-Tax Premiums

The two dental insurance plans are pre-tax benefits. This means that premiums are paid before withholding taxes are taken from the paycheck. Consequently, premiums are not subject to state or federal taxes (please refer to the *Affidavit of Domestic Partnership* form for more information regarding exceptions to this rule).

How to Enroll

Employee Benefits provides a detailed plan comparison, Evidences of Coverage, and plan brochures for each dental plan describing their respective services. To select a dental plan, please carefully read these materials. Employees have two options for enrollment:

1. Enroll on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required except for the *Affidavit of Domestic Partnership* if adding a domestic partner and/or proof of alternate coverage if enrolling in the Health In-Lieu plan.

2. Complete and return the City's *Health, Dental, & Vision Enrollment/Change Form* to Employee Benefits within the first thirty (30) days of the date of hire/benefits eligibility. A marriage certificate, *Affidavit of Domestic Partnership*, or *Request to Add Dependents* form will be required if adding a spouse, domestic partner, or child dependent(s).

Default Enrollment

If an employee does not turn in the *Health, Dental, & Vision Enrollment/Change Form* within the first 30 days of employment, he/she will be enrolled in the DeltaCare HMO plan (unless the *Request to Waive Insurance* form is completed, which is available in Human Resources). Dependents will not be enrolled. An employee will have to wait for the annual open enrollment period in November to change to another plan or to enroll dependents. Any change made at open enrollment will not take effect until January of the following year.

When Does Coverage Begin?

An employee and his/her eligible dependents may use the selected dental plan starting on the first day of the month following the date of enrollment. The employee will be given the date on which coverage takes effect during on-line enrollment or when Employee Benefits receives the completed enrollment form.

Coordination of Benefits

If the employee or his/her dependents are entitled to benefits under more than one dental plan (dual coverage), benefits are calculated so that payments by all plans will not be greater than the total cost of the covered services received. If dual coverage does exist, and the benefit amount exceeds the co-payment fee, then no co-payment fee will be charged to the patient.

DeltaCare will coordinate benefits only if a non-emergency service is provided through a DeltaCare dentist that has already been selected as the primary care dentist. The DeltaCare Prepaid Dental Plan makes no payment toward dental work done at any other location except in an emergency situation when DeltaCare may reimburse you up to $100 for covered procedures.

Employees should inform their dentist about all dental plans under which they and their family are covered.

Dental Insurance Claims Appeal/Complaint Procedures

The insurer is responsible for making the final determinations for benefits described in this handbook. To appeal the denial of any insurance claim, write to the dental insurance company within sixty (60) days of the denial.

AFTER contacting the dental insurance company to file an appeal and utilize the plan's grievance process, an employee may file a complaint against their dental plan, with the California Department of Managed Health Care (DMHC). The DMHC requires that the dental plan provider advise their members of the following:

> *The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number (1-800-400-0815) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)) to contact the department. The department's Internet website (http://www.dmhc.ca.gov) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan and use the plan's grievance process before contacting the department. If you need help with*

a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

When Coverage Terminates

Dental coverage for the employee or his/her dependents will end on the last day of the month in which benefits eligibility or enrollment terminates. Continuation of coverage may be available. Refer to the *COBRA Coverage* section of this document for more information about Health, Dental, Vision, MRA or EAP benefits continuation for employees and their qualified dependents.

DENTAL PLAN OPTIONS

DELTA DENTAL PPO PLAN OF CALIFORNIA
DELTA PREFERRED OPTION (PPO) PLAN
(GROUP # 2584)

Delta Dental PPO of California is an indemnity dental plan. A covered member may go to any dentist and may change dentists at any time.

Summary Benefit Information

Currently, the annual maximum benefit for dental services per person per calendar year is $1,500 with no annual deductible (*Note: bargaining groups (unions) negotiate changes in coverage periodically on an individual basis. Consult the latest Memorandum of Agreement (MOA) or Benefit and Compensation Summary to find out what the annual maximum is).*

Delta generally pays 85% of the covered benefit for basic and routine services.

Delta generally pays 85% for crowns, 60% for dentures and bridges.

Delta currently pays 60% of orthodontic costs up to a lifetime maximum of $2,000 per person. All orthodontia work must be pre-approved by Delta and must be medically necessary in order to receive coverage. (*Note: As with annual maximum benefit, please consult the latest MOA or Benefit and Compensation Summary to find out what the current lifetime maximum is).*

Delta will pay 100% of the covered benefit for diagnostic and preventative services if the dentist is a Delta PPO (Delta Preferred Option) member. Contact your dentist to find out if he/she is a PPO member, call Delta, or use Delta's web site to find a PPO dentist in your area.

Delta Dental does not send new enrollees a member card upon their initial enrollment; however, access to coverage is always available by providing the employee's name, social security number and the City's Delta Dental group number (2584) to the dentist upon request.

For more detailed coverage information, please refer to Delta Dental's *Evidence of Coverage* available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285), or on the department's intranet site: www.csj.gov.

Contact Delta Dental

Delta Dental's Customer Service Center (1-800-765-6003) can assist with questions regarding claims, eligibility, usage, and network. An employee may also find personalized information by logging on to Delta Dental's website. If an employee has already enrolled in Delta Dental, name and social security number recognition on their website will become available within two weeks of the initial effective date of coverage. Login instructions are provided within the site.

Contact Delta by phone: 1-800-765-6003

Or visit their web site: www.deltadentalca.org

DELTACARE USA
DENTAL HMO PLAN
(GROUP #5643)

DeltaCare is a prepaid dental health maintenance organization (DHMO) that provides direct services through its exclusive dentist network. An employee must select a primary care dentist from the list of DeltaCare providers when he/she enrolls in DeltaCare.

Summary Benefit Information

- Unlimited annual benefit for dental services. No annual deductible.
- DeltaCare generally pays 100% of the covered benefit for most diagnostic and preventative services.
- General cleanings/exams are allowed twice in a calendar year at no cost. Two additional cleanings are available in the same calendar year for a $45 co-pay per cleaning.
- When there is a co-pay for crowns and bridges, enrollees pay a fixed amount for each covered dental procedure.
- The patient will be responsible for a co-payment of $1,000 for medically and non-medically necessary orthodontia. Coverage is limited to once per eligible member per lifetime.
- Teeth whitening (external bleaching – per arch) is covered at $125 per arch when accessed from the patient's primary care dentist.
- DeltaCare will send new enrollees a member card within 7-10 business days after enrollment; however, access to coverage is available by providing the employee's social security number and the City's DeltaCare group number (5643) at the first visit with the patient's primary care dentist.
- For more detailed access or coverage information, please refer to DeltaCare's dental plan co-payment booklet or *Evidence of Coverage* available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285), or on the department's intranet site: www.csj.gov.

Contact DeltaCare

DeltaCare's Customer Service Center (1-800-422-4234) can assist with questions regarding claims, eligibility, usage, and network. An employee may also find personalized information by logging on to DeltaCare's website. If an employee has already enrolled in DeltaCare, name, date of birth, and social security number recognition on their website will become available within two weeks of the initial effective date of coverage. Log-in instructions are provided within the site.

Contact DeltaCare/PMI by phone:	1-800-422-4234
Or visit their web site:	www.deltadentalca.org/deltacareusa/

DENTAL IN-LIEU PLAN

The City of San Jose's Dental In-Lieu plan provides eligible employees a cash incentive to forego coverage under one of the City's available dental plans when employees can furnish proof of alternate coverage.

Eligibility

Full-time and Reduced Work Week (35+ hours per week) employees who have alternate dental insurance coverage through another group dental plan may participate in the Dental In-Lieu plan, or may choose coverage under one of the two dental plans described above.

In-Lieu Payments

Participants in the Dental In-Lieu plan receive a cash payment of 50% of the City's contribution to the cost of dental insurance, in-lieu of coverage. Payments appear on each paycheck; federal and state taxes are withheld on each payment. Dental In-Lieu payment amounts are available on the *Health and Dental Bi-Weekly Rates* sheet available in Human Resources (City Hall Wing, 2nd Floor, 535-1285) and on the department's intranet site: www.csj.gov.

How to Enroll

Employees have two options for enrollment:

Enroll on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required except for proof of alternate coverage, which can be submitted within two weeks of enrollment.

Complete and return the City's *Health, Dental, & Vision Enrollment/Change Form* and check off 'Dental In-Lieu' as your choice. Return this form to Employee Benefits within the first thirty (30) days of the date of hire/benefits eligibility. Employees MUST provide evidence of acceptable alternate dental coverage at the time of enrollment. Re-enrollment is not necessary; payments will continue from one year to the next.

Enrollment Period

To participate in the Dental In-Lieu plan, an employee must enroll within thirty (30) days of the first day of employment, or during the open enrollment period in November. An employee may apply for Dental In-Lieu during the year only if he/she becomes eligible due to a Change in Family Status, and he/she must apply within 30 days of the date of that change. A change in Family Status is defined as follows:

Change in marital status – marriage, divorce, or legal separation
Change in dependent status – birth, adoption, legal guardianship, or death

Change in work status (either employee or employee's spouse) – termination of employment, commencement of employment, or change between part-time and full-time employment

If an employee decides to enroll in the Dental In-Lieu plan after the first 30 days of employment, or if he/she misses the 30-day time limit after a Change in Family Status, he/she must wait for the next open enrollment period.

Voluntary Cancellation

Employees who participate in the Dental In-Lieu Plan **may cancel** their participation and enroll in one of the available dental insurance plans **during open enrollment only**. Cancellation will become effective with the first pay period of the following calendar year.

An employee may be allowed to make a mid plan-year enrollment change (outside of Open Enrollment) only if he/she has a Change in Family Status (see details above under "Enrollment Period".) Employee Benefits must be contacted within 30 days of such family status changes to inquire about changing plan enrollments.

Mandatory Cancellation

If an employee enrolls in the Dental In-Lieu plan and alternative coverage is lost prior to the next open enrollment period, he/she **must** notify Employee Benefits immediately. Upon receipt of documentation that coverage has been lost (from the providing employer or group insurer) the employee may enroll in either of the two City dental insurance plans.

Excess In-Lieu Payments Received

If an employee cancels the Dental In-Lieu plan and enrolls in an available dental insurance plan due to loss of alternate dental coverage, the City's policy is to make coverage in the dental plan effective the date the employee's alternative coverage is lost. EMPLOYEES ARE RESPONSIBLE FOR REPAYMENT OF ANY EXCESS DENTAL IN-LIEU PAYMENTS THEY MAY HAVE RECEIVED. EMPLOYEES ARE ALSO RESPONSIBLE FOR PAYING THE EMPLOYEE PORTION OF PREMIUMS NECESSARY TO BEGIN THE CITY DENTAL PLAN COVERAGE FOLLOWING CESSATION OF THEIR ALTERNATE DENTAL COVERAGE.

VISION CARE INSURANCE

Vision Care Insurance is a voluntary benefit and the City offers a choice of two vision care plans: EyeMed Vision Care plan and Vision Service Plan (VSP). A brief summary of each plan is presented here. Plan information and rate sheets are available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285) or on the department's intranet site: www.csj.gov.

Eligibility

All full-time and part-time benefited employees may enroll themselves and their eligible dependents in one of two City vision plans.

Cost

Please refer to the applicable MOA or Benefit and Compensation Summary to determine if the City contributes towards the cost of vision care insurance. The premiums are subject to change each year in July in accordance with contract renewals. Information on current premium rates is available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285). Please contact the Office of Employee Relations (City Hall Wing, 2nd Floor, 535-8150) for more information regarding the City's cost sharing arrangement.

Pre-Tax Premiums

The two vision plans are pre-tax benefits. This means that premiums are paid before withholding taxes are taken from the paycheck. Consequently, premiums are not subject to state or federal taxes (please refer to the *Affidavit of Domestic Partnership* form for more information regarding exceptions to this rule).

How to Enroll

Employee Benefits provides a detailed plan comparison and plan brochures for each vision plan describing their respective services. To select a vision plan, please carefully read these materials. Employees have two options for enrollment:

Enroll on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required except for the *Affidavit of Domestic Partnership* if adding a domestic partner and/or proof of alternate coverage if enrolling in the Health In-Lieu plan.

Complete and return the City's *Health, Dental, & Vision Enrollment/Change Form* to Employee Benefits within the first thirty (30) days of the date of hire/benefits eligibility. A marriage certificate, *Affidavit of Domestic Partnership*, or *Request to Provide Dependents Coverage* form will be required if adding a spouse, domestic partner, or child dependent(s).

When Does Vision Care Coverage Begin?

Employees and their eligible dependents may use the selected vision plan starting on the first day of the month following the date of enrollment. Employees will be given

the date on which coverage takes effect during on-line enrollment or when Employee Benefits receives the completed enrollment form.

Mandatory 24-Month Vision Plan Commitment

IN ORDER TO ENROLL IN EITHER VISION PLAN, AN EMPLOYEE MUST BE WILLING TO REMAIN ENROLLED FOR 24 MONTHS. THIS MANDATORY 24-MONTH COMMITMENT IS IN PLACE TO ENSURE THAT VISION PLAN RATES REMAIN STABLE. EMPLOYEES MAY ONLY DROP COVERAGE OR SWITCH PLANS DURING OPEN ENROLLMENT AFTER THE 24-MONTH REQUIREMENT IS MET.

Vision Insurance Claims Complaint/Appeal Procedures

The insurer is responsible for making the final determinations for benefits described in this handbook. To appeal the denial of any insurance claim, write to the vision insurance company within sixty (60) days of the denial.

AFTER an employee has contacted the vision insurance company to file an appeal and utilize the plan's grievance process, he/she may file a complaint against the vision plan, with the California Department of Managed Health Care (DMHC). The DMHC requires that the vision plan provider advise their members of the following:

> *The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number (1-800-400-0815) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)) to contact the department. The department's Internet website (http://www.dmhc.ca.gov) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at (1-800-877-7195) and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.*

When Coverage Terminates

Vision coverage for employees or their dependents will end on the last day of the month in which benefits eligibility or enrollment terminates. Coverage will also terminate if he/she chooses to drop vision plan enrollment (after completing the 24-month commitment).

Continuation of coverage may be available. Refer to the *COBRA Coverage* section of this document for more information about Health, Dental, Vision, MRA or EAP benefits continuation for employees and their qualified dependents.

VISION PLAN OPTIONS

EYEMED VISION CARE
(GROUP# 9681586)

EyeMed Vision Care is the largest optical retailer in the United States, operating primarily under the "Pearle Vision", "LensCrafters", "Sears Optical", and "Target Optical" names.

Summary Benefit Information

Office Visit:	$10 Co-pay
Spectacle Exams:	Paid in full every 12 months (Contact lens exams may require additional fees)
Spectacle Lenses:	Paid in full every 12 months (Options other than 'standard' are available at additional cost)
Covered Frames:	Paid up to $115 retail allowance every 12 months (Alternative frames may involve additional cost)
Contact Lenses:	Paid up to $250 every 12 months if medically required (Covered up to $100 retail if elected in lieu of spectacles)

Accessing In-Network Services

Contact the facility at which you intend to receive services. Provide the facility with the covered employee's name, social security number, and the City of San Jose's group number (9681586). The facility will contact EyeMed Vision Care to verify eligibility and setup the appointment.

Accessing Out-of-Network Services

Coverage for services is reduced for services accessed out of the EyeMed Vision Care network of providers and facilities. Employees should contact EyeMed Vision Care prior to accessing out-of-network services whenever possible to verify limitations or exclusions in coverage. The covered member will be responsible for paying the provider in full at the time services are rendered. For reimbursements, simply call EyeMed's Customer Service Center at 1-866-723-0514 to verify eligibility and receive a claim form.

Contact EyeMed Vision Care

EyeMed Vision Care's Customer Service Center can assist with questions regarding claims, eligibility, usage, and network. Though EyeMed Vision Care does not provide member-specific information on-line, provider lists can be found on their Internet website.

Contact EyeMed by phone:	1-866-723-0514
Or visit their web site:	www.eyemedvisioncare.com

VISION SERVICE PLAN (VSP)
(GROUP#12112926)

Vision Service Plan (VSP) is the nation's leading vision plan. Members receive care from a national network of more than 18,000 independent optometrists and ophthalmologists.

Summary Benefit Information

Office Visit:	$10 Co-pay
Spectacle Exams:	Paid in full every 12 months (Contact lens exams may require additional fees)
Spectacle Lenses:	Paid in full every 12 months (Options other than 'standard' are available at additional cost)
Covered Frames:	Paid up to $115 retail allowance every 24 months (Alternative frames may involve additional cost)
Contact Lenses:	Paid in full every 12 months if medically required (Covered up to $105 retail if elected in lieu of spectacles)

Accessing In-Network Services

Contact a participating VSP vision provider's office. Give them the covered employee's name, date of birth, Social Security Number, and notify them that you have coverage under the City of San Jose's VSP plan (Group#: 12112926). The provider's office will then verify eligibility with VSP and schedule an appointment.

Accessing Out-of-Network Services

Coverage for services is reduced for services accessed out of the Vision Service Plan network of providers. Employees should contact VSP prior to accessing out-of-network services whenever possible to verify limitations or exclusions in coverage. Covered members are responsible for paying the provider in full at the time services are accessed. At that time, request an itemized receipt of products and services rendered. Then send this information along with a letter requesting reimbursement to:

Vision Service Plan
PO Box 997100
Sacramento, CA 95899-7100

Be sure to include the Employee's social security number, name, the City's group number, the patient's name, relationship to employee, date of birth, phone number, and address.

VSP Insurance Claims Complaint/Appeal Procedures

If a subscriber/enrollee (hereafter "enrollee") has a complaint/grievance (hereafter "grievance") regarding VSP service or claim payment, the enrollee may communicate

the grievance to VSP by using a form which is available by calling VSP's Customer Service Department's toll free number (1-800-877-7195) Monday through Friday, 6:00 a.m. to 7:00 p.m. (PST). Grievances may be filed in writing with VSP at 333 Quality Drive, Rancho Cordova, California 95670.

Upon receipt of a verbal or written grievance, VSP will respond in writing to the enrollee acknowledging receipt and/or disposition of the grievance within five (5) business days. VSP is generally responsible for resolving grievances within thirty (30) days from the date of receipt. VSP will keep all grievances and the responses thereto on file for seven years.

Contact Vision Service Plan

VSP's Customer Service Center can assist with questions regarding claims, eligibility, usage, and network. Personalized information regarding these areas is also available on VSP's website. The employee's social security number and last name will be requested for access.

Contact VSP by phone:	1-800-877-7195
Or visit their web site:	www.vsp.com

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Counseling services are available for marital, family, interpersonal, emotional and drug abuse issues. In addition, a number of life management services are available to help you with child & elder care, legal, financial, credit, IRS, and retirement issues.

Eligibility

All full-time and part-time benefited employees and their eligible dependents may access EAP counseling and life management services.

Cost

The eligible employee pays nothing to participate. The City of San Jose contributes 100% of the monthly premium.

How to Enroll

All full-time or part-time benefited employees are automatically enrolled.

When Does EAP Coverage Begin?

Employees and their eligible dependents may use the counseling or life management services on the first of the month following the date of hire or benefits eligibility.

Counseling Benefits

The first five (5) visits* per incident per year are free. If additional appointments are necessary, out-of-pocket payment is required. However, City employees will pay a reduced rate for additional counseling services.

If an incident is exceptionally serious, the counselor may refer the participant to a psychologist or to another agency in a special field of expertise.

If an employee is referred to EAP by his/her supervisor for a work-related problem, he/she does not have to pay for additional appointments after the first 5 appointments. Visiting an EAP counselor at the recommendation of the employee's supervisor is usually voluntary, but in some cases it may be mandatory. Refer to the applicable MOA or Benefit and Compensation Summary for specific information.

* The limit of five (5) visits per incident does not apply to sworn police and fire employees, safety dispatchers, and their respective dependents.

Work and Life Services

Unlimited telephone consultations are available to employees and their eligible dependents for life management services. Examples of work and life consultation areas include Pre-Retirement Planning, Financial Planning, Child & Elder Care Referral, Taxpayer Consultations, Legal Guidance (for questions regarding wills & contracts or questions related to family, real estate, personal injury, criminal and consumer law), and Concierge Services.

Telephone consultation sessions are usually limited from 30 to 60 minutes for each call; however, eligible participants are entitled to an unlimited number of free consultations throughout the year.

Accessing EAP Services

Contact Managed Health Network (MHN) directly to schedule counseling or work and life services by calling the following toll-free number: **1-800-227-1060** ***(TDD Line: 1-800-327-0801)***.

Inform the MHN intake staff that coverage is under the City of San Jose's EAP program. Also, provide your name and the City employee's name under whom you are covered. MHN will require this information to verify eligibility for services**.**

Confidentiality Assurance

Visits to a counselor are completely confidential unless the participant undergoing counseling authorizes the release of information by signing a release form. If service issues are encountered with an MHN provider or facility and the employee or dependent is concerned about maintaining privacy within the City, refer to the EAP Service Disputes and Complaints section below.

EAP Service Complaint/Appeals Procedures

For complaints or disputes about MHN's services or practitioners, call the toll-free number: 1-800-887-1060 or submit a complaint in writing to: *MHN, Quality Management Department, 1600 Los Gamos Drive, Suite 300, San Rafael, CA 94903.*

Complaints are investigated and resolved by MHN Quality Management staff. Complaints are acknowledged within 5 working days and, with specific exceptions, are resolved within 30 days of MHN's receipt of the complaint. If you are dissatisfied with the outcome of your complaint, you may appeal in writing to: *MHN, Appeal Unit, 5100 Goldleaf Circle, Suite 300, Los Angeles, CA 90056.*

If help is needed with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the Plan, or a grievance that has remained unresolved for more than 30 days, call the DMHC at 1-888-HMO-2219. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers: 1-800-735-2929 (TTY) or 1-888-877-5378 (TTY) to contact the DMHC. The DMHC's website (www.dmhc.ca.gov) also has complaint forms and instructions online.

When Coverage Terminates

EAP coverage will end on the last day of the month in which the employee's employment or benefits eligibility terminates. Dependents' coverage will end on the last day of the month in which either the employee or his/her dependents are no longer eligible.

Continuation of coverage may be available. Refer to the *COBRA Coverage* section of this document for more information about Health, Dental, Vision, EAP, or MRA benefits continuation for the employee and the employee's qualified dependents.

Additional Information

For more information on EAP services for the employee and the employee's family, information is available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285), or on the department's Intranet site: www.csj.gov.

COBRA COVERAGE

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) provides that the same health, dental, vision, MRA, and EAP benefits be made available for employees, former employees, and dependents when they lose coverage after a qualifying event.

Employee Rights

COBRA allows benefited employees (and any covered dependents) to continue health, dental, vision, MRA, or EAP benefits at their own expense for thirty-six (36) months after the month in which one of the following qualifying events occurs:

Termination of employment (other than for gross misconduct).

Loss of benefited status whether by reduction in work hours or change in job classification.

Dependent Rights

Employees' covered dependents may continue their coverage for thirty-six (36) months after one of these qualifying events:

An employee's death.

A divorce or legal separation from an eligible employee.

A dependent child's loss of dependent status (either for a dependent child who is not a full-time student between age 19 and age 24, or for a dependent child who turns 24).

Definition of 'Eligible' or 'Qualified' Dependents

For purposes of COBRA, a qualified dependent is defined as any individual who, on the day before the qualifying event, was a covered spouse, domestic partner or a covered dependent child of an employee; or who was born to or adopted by the employee during the COBRA continuation period.

Eligibility Notifications

When an employment or family status change occurs in the City's HR/Payroll system that results in the employee or family members' loss of benefits eligibility (such as separation from City service, loss of benefited status, divorce, or a dependent child's loss of FT student status), the City will notify the qualified beneficiaries of their COBRA rights within 14 days of the qualifying event or upon receiving notification of the same. Consequently, if the employee or his/her dependent ceases to become eligible for the City's Health, Dental, Vision, MRA, or EAP benefits, he/she must inform Employee Benefits (535-1285) immediately.

Election Requirements

If coverage continuation under COBRA is desired, the employee or eligible dependent must notify the City within sixty (60) days after receiving the City's notification of the qualified beneficiaries' COBRA rights, or within sixty (60) days after losing coverage after a qualifying event, whichever is later.

The COBRA participant will then have forty-five (45) days to make the initial premium payment along with any subsequent premiums due for months following the qualifying event. The cost to continue coverage under COBRA will be the total cost of the premium plus a minimal administrative fee which cannot legally exceed 2% above the premium cost for active employees.

Contact Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285) for more information regarding administration and premium remittance.

When Does COBRA Coverage End?

Continued coverage under COBRA will terminate at the end of the month in which any of the following occur:

The allowable number of months of continued coverage expires.

Premiums are not paid as required.

The COBRA participant becomes eligible for health benefits under another health plan, or becomes eligible for Medicare benefits.

Once COBRA Coverage Terminates, It Cannot Be Reinstated.

Health Insurance Portability and Accountability Act (HIPAA)

The City of San Jose does not exclude anyone with pre-existing medical conditions from health, dental, vision, or EAP coverage. However, if you leave City employment for another job, your new employer may have such exclusions. A pre-existing medical condition exclusion generally may not be imposed for more than 12 months, and this limitation period is reduced if you had prior health coverage. You are entitled to a *Certificate of Creditable Coverage* that provides evidence of prior health coverage. Your City health insurer will provide this *Certificate of Creditable Coverage* when your City health coverage ends. Contact Employee Benefits if your new employer or individual health insurer asks for a *Certificate of Creditable Coverage* and you did not receive one from your former City health insurer.

Additional Information

For any questions about COBRA continuation or to take advantage of your COBRA opportunity, please contact Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285).

MEDICAL REIMBURSEMENT ACCOUNT (MRA)

The City offers its employees a Medical Reimbursement Account (MRA) in accordance with IRS Sections 125/129. The current Plan Administrator (account manager) is New Liberty. Normally, out-of-pocket healthcare expenses are paid with money that has already been taxed. However, using the MRA program, out-of-pocket expenses can be reimbursed from a trust account funded with pre-tax deductions from the employee's paycheck. This reduces taxable income so City employees will pay less in taxes and have more money to spend and save.

Eligibility

All Full and Part-time benefited employees are eligible to participate in the Medical Reimbursement Account (MRA).

Cost

There are no administrative fees for participating in one or both of the City's Flexible Spending Accounts: MRA or DCAP.

How to Enroll

Employees have two options for enrollment:

Enroll on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required.

Contact New Liberty at (866) 639-5289 to enroll within 30 days of the date of hire or benefits eligibility. If enrollment is not received within 30 days, employees will be required to wait until Open Enrollment in November to enroll for the following calendar year. More information is available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285).

Reimbursable Expenses

The following are examples of expenses that qualify as 'reimbursable' under the MRA plan:

1. Insurance co-payments
2. Unreimbursed medical/dental expenses
3. Acupuncture, Chiropractic, Homeopathic Therapy, etc.
4. Contact lens solution
5. Laser eye surgery

Please consult the MRA plan administrator for a complete and current list of eligible expenses.

"Use It or Lose It" Rule

At the time of enrollment, be sure to designate an annual amount that will cover only expenses that you know you will have during the plan year. If you do not spend all

the money that you designated for the plan year, the remaining account balance is lost. It cannot be returned to you according to the IRS' "use it or lose it" rule.

Plan Year Grace Period

The IRS allows MRA participants to continue to incur expenses for 2 ½ months after the end of the plan year. For example, if you were enrolled in the MRA for the 2007 plan year, you could continue to incur expenses for reimbursement until March 15, 2008. Participants would be reimbursed from any balance remaining in the account from the 2007 plan year election.

How the Plan Works

With the assistance of the Plan Administrator or a tax advisor, the employee will need to estimate his/her annual out-of-pocket healthcare expenses.

That amount is divided by 24 pay periods in a year and deducted from each paycheck semi-monthly before taxes are applied to the gross earnings. This reduces the amount of money on which the employee has to pay taxes.

After the money is deducted, it is banked in a tax-free reimbursement account.

Upon request, the Plan Administrator or Employee Benefits will provide the employee with a *Benefit Reimbursement Voucher* to use for reimbursement requests. Employees may request reimbursement biweekly, monthly, or once a year; it is their choice.

Requests for reimbursement will be processed within three (3) days after the Administrator receives a complete, accurate form. A check or direct deposit will be issued for the amount requested from the Reimbursement Account soon thereafter.

Periodically throughout the year, the Plan Administrator will provide an account statement. These statements should be read carefully to understand the amount remaining in the reimbursement account.

Tax Advantage Illustration

	Without MRA/DCAP	**With MRA/DCAP**
Annual Income:	$51,000	$51,000
Designated Annual Amount:	- $ 0	- $ 1,000
Taxable Income:	$51,000	$50,000
Taxes Taken Out at 25%*:	- $12,750	- $12,500
Take-home Pay (*After Taxes*):	$38,250	$37,500
Out-of-Pocket Expenses:	- $1,000	- $1,000
Reimbursements (*Using Pre-Tax Deductions*)	$0	$1,000
Net Income:	$37,250	$37,500
Annual Tax Savings*:		**$250**

** This example is for illustration purposes only. In no way should this example be used to calculate your actual tax savings. Please consult a qualified tax advisor for more information about how these pre-tax programs will benefit you, specifically.*

When Does MRA Participation Terminate?

The MRA account will close at the end of each calendar year. Eligibility to participate prospectively in this pre-tax program will end either on the last day of the calendar year or on the last day employed or the last day on which the employee was eligible for the MRA benefit. If the employee participated in a plan year and at some point separated from City service or ceased to be eligible for the MRA benefit, he/she may request reimbursements from the account retroactively for the period in which he/she was an active participant.

Additional Information

For more detailed summary information, New Liberty's brochure on the Flexible Spending Account Program is available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285).

For answers to more specific questions about the City's Medical Reimbursement Account program please call New Liberty: 1-866-639-5289 or visit their website at www.newliberty.net .

DEPENDENT CARE ASSISTANCE PROGRAM (DCAP)

The City offers its employees a Dependent Care Assistance Program (DCAP) in accordance with IRS Sections 125/129. The current Plan Administrator (account manager) is New Liberty. Normally dependent care is paid for with money that has already been taxed. However, using the DCAP program, out-of-pocket expenses can be reimbursed from a trust account funded with pre-tax deductions from the employee's paycheck. This reduces taxable income so City employees will pay less in taxes and have more money to spend and save.

Eligibility

All Full and Part-time benefited employees may be eligible to participate.

The employee must be at work while his/her child or other dependent is receiving care. If married, the employee's spouse must also be employed, or be a full-time student, or be disabled.

Eligible children must be 12 or under. Other dependents (such as children age 13 or over, parents, or a spouse) are eligible only if they are disabled or cannot care for themselves because of physical or mental disability.

The child, or other dependent, receiving care must live in the employee's home, and must be claimed as a dependent on the employee's federal income tax return.

The employee must pay a "qualified person" to care for his/her eligible dependent at the employee's home, at a licensed day care center, or at another location. Any overnight camps or any schools for first grade or above are **not** qualified. A "qualified person" does **not** include any of your children under 19, or any other person whom the employee claims as a dependent.

The employee must show the name, address, and taxpayer identification number of any persons or dependent care centers that he/she pays to provide dependent care on your federal income tax return.

Cost

There are no administrative fees for participating in one or both of the City's Flexible Spending Accounts: MRA or DCAP.

How to Enroll

Employees have two options for enrollment:

Enroll on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required.

Contact New Liberty at (866) 639-5289 to enroll within 30 days of the date of hire or benefits eligibility. If enrollment is not received within 30 days, employees will be required to wait until Open Enrollment in November to enroll for the following calendar year. More information is available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285).

Qualified Dependent Care

The following types of dependent care arrangements qualify for the DCAP plan:

A dependent day care center where care is provided for more than six (6) individuals. The facility must comply with applicable state and local laws.

An educational institution for pre-school children. For older children, only expenses for non-school care are eligible.

An individual who provides care inside or outside your home. This person may not be the employee's child under 19, or anyone he/she claims as a dependent for Federal tax purposes.

"Use It or Lose It" Rule

At the time of enrollment, be sure to designate an annual amount that will cover only expenses that you know you will have during the plan year. If you do not spend all the money that you designated for the plan year, the remaining account balance is lost. It cannot be returned to you according to the IRS' "use it or lose it" rule.

How the Plan Works

With the assistance of the Plan Administrator or a tax advisor, the employee will be asked to estimate his/her annual out-of-pocket dependent care expenses.

That amount is divided by 24 pay periods in a year and deducted from each paycheck semi-monthly before taxes are applied to the gross earnings. This reduces the amount of money on which the employee has to pay taxes.

After the money is deducted, it is banked in a tax-free reimbursement account.

Upon request, the Plan Administrator or Employee Benefits will provide the employee with a *Benefit Reimbursement Voucher* to use for reimbursement requests. Employees may only request reimbursement for expenses as they contribute to the DCAP account. **Employees may not request reimbursement in excess of their year-to-date deposits**.

Requests for reimbursement will be processed within three (3) days after the Administrator receives a complete, accurate form. A check or direct deposit will be issued for the amount requested from the Reimbursement Account soon thereafter.

Periodically throughout the year, the Plan Administrator will provide an account statement. These statements should be read carefully to understand the amount remaining in the reimbursement account.

Tax Advantage Illustration

	Without MRA/DCAP	With MRA/DCAP
Annual Income:	$51,000	$51,000
Designated Annual Amount:	- $ 0	- $ 1,000
Taxable Income:	$51,000	$50,000
Taxes Taken Out at 25%*:	- $12,750	- $12,500
Take-home Pay (*After Taxes*):	$38,250	$37,500
Out-of-Pocket Expenses:	- $1,000	- $1,000
Reimbursements (*Using Pre-Tax Deductions*)	$0	$1,000
Net Income:	$37,250	$37,500
Annual Tax Savings*:		**$250**

** This example is for illustration purposes only. In no way should this example be used to calculate your actual tax savings. Please consult a qualified tax advisor for more information about how these pre-tax programs will benefit you, specifically.*

When Does DCAP Participation Terminate?

The DCAP account will close at the end of each calendar year. Eligibility to participate prospectively in this pre-tax program will end either on the last day of the calendar year or on the last day employed or the last day on which the employee was eligible for the DCAP benefit. If the employee participated in a plan year and at some point separated from City service or ceased to be eligible for the DCAP benefit, he/she may request reimbursements from the account retroactively for the period in which he/she was an active participant.

Additional Information

For more detailed summary information, New Liberty's brochure on the Flexible Spending Account Program is available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285).

For answers to more specific questions about the City's Dependent Care Assistance Program please call New Liberty: 1-866-639-5289 or visit their website at www.newliberty.net .

LIFE INSURANCE

The City provides coverage through a group policy with Standard Insurance Company.

Eligibility

All full-time benefited employees are eligible to participate in the City's group life insurance policy (part-time benefited and temporary employees are not eligible for life insurance). Employees are eligible for Basic, Supplemental, and Dependent coverage options.

Cost

The amount of Life Insurance provided by the City is specified in the applicable Memorandum of Agreement (MOA) or Benefits and Compensation Summary.

For details on Supplemental and Dependent coverage premiums please contact Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285) or refer to the department's intranet site: www.csj.gov. Premiums are paid through regular after-tax payroll deductions and are subject to change each July.

Management employees should note that the Basic coverage premiums paid by the City for Basic coverage exceeding $50,000 are subject to federal taxation as additional earnings in accordance with IRS rules (only the premium is taxed, not the coverage amount).

How to Enroll

Employees have two options for enrollment:

Employees can enroll and select beneficiaries on-line through the City's Intranet site, www.csj.gov/eway, for Basic Life, Dependent Life and Supplemental life insurance, (for one (1x) times or two (2x) times your annual salary, up to $300,000), during the first 30 days after hire or benefits eligibility. No paper forms are required.

Employees can enroll using paper forms. Please note that the *Medical History Statement* is required for supplemental life amounts of three or four times your annual salary.

Basic and Dependent Coverage (1st 30 Days) – Complete the enrollment card at the back of the life insurance brochure to indicate the coverage to be elected. Basic and Dependent coverage will be guaranteed if enrollment occurs within the first 30 days of employment or benefits eligibility, so no *Medical History Statement* will be required for these options.

Supplemental Coverage: additional one (1x) times or two (2x) times your annual salary (1st 30 Days) –Supplemental life insurance coverage of 1x or 2x your annual salary, up to $300,000, will be guaranteed if enrollment occurs within

the first 30 days of employment or benefits eligibility, so no *Medical History Statement* will be required for this option.

Supplemental Coverage: up to four (4x) times your annual salary (1st 30 Days) – If Supplemental life insurance coverage over the guaranteed two (2x) times annual salary and/or the $300,000 cap is desired, the employee must apply by completing a *Medical History Statement* form. The application for coverage will be subject to The Standard Insurance Company's underwriting review process. Notification of denial/approval will be sent once a determination has been made by The Standard Insurance. Supplemental coverage will become effective on the day of approval. Deductions will begin shortly thereafter.

Basic, Supplemental, & Dependent Coverage (After the 1st 30 Days) – To enroll in any of the coverage options or to increase coverage after the first thirty (30) days of employment, the employee must complete a *Medical History Statement* for Basic, Supplemental, and Dependent coverage. Approval will be subject to The Standard Insurance Company's medical underwriting review. If the employee is approved, coverage will begin the on the date of approval.

Return the enrollment card to Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285). At that time, Employee Benefits will notify the employee when the guaranteed coverage (if applicable) takes effect.

Basic Life Insurance (City Paid)

Basic Life Insurance amounts are specified in the applicable MOA or Benefits & Compensation summaries. Current life insurance rates as outlined in the MOAs and compensation summaries are as follows:

- Non-management: All full-time non-management employees are insured for $10,000 (IAFF and POA), or $20,000 (all others), as shown in the applicable MOA.
- Management: All management employees are insured for twice their annual salary, up to a maximum of $750,000.

Supplemental Life Insurance (Employee Paid)

- Non-management: Non-management employees, if eligible, may purchase additional life insurance worth up to four (4x) times their annual salary, up to a maximum of $750,000. Eligibility is based upon medical underwriting approval as determined by The Standard Insurance Company. Employees pay premiums for this insurance through regular payroll deductions.
- Management: Management employees may purchase additional life insurance worth up to two (2x) times their annual salary, up to a maximum of $750,000. Eligibility is based upon medical underwriting approval as determined by The Standard Insurance Company. Employees pay premiums for this insurance through regular payroll deductions.

Dependent Life Insurance Coverage (Employee Paid)

Employees may purchase coverage, in increments of $2,000 to a maximum of $10,000, for their spouse or domestic partner and dependent children. The

employee's spouse or domestic partner and each child will have the same amount of coverage.

Life Insurance Retirement Provisions

Retired City employees have three options for life insurance. *In all cases, the employee must apply within 31 days of retirement.*

Option 1. Retired City employees may purchase a lesser amount of life insurance through the City's group policy. The value of the coverage declines in steps during the employee's retirement:

- Non-Management: Life insurance coverage drops to $5,000 upon retirement. At age 65, it drops to $2,500.
- Management: Life insurance coverage drops to $20,000 upon retirement. At age 65, it drops to $10,000; and at age 70, it drops to $5,000.
- Dependents Life: Retirees may choose the Dependents Life option of $1,000 coverage (may not exceed 50% of employee's amount).

Option 2. Employees may port Life Insurance up to the lesser of (a) the amount of Basic Life plus Additional Life in force on the employee's last day of work or (b) $300,000. The employee may also port Spouse and Child's coverage (maximum is the amount in effect on the employee's last day of work). To be eligible for this option, the Employee must be:

Under age 70

Must have had insurance for at least 12 months

Must be able to work in one occupation

If porting dependent's coverage, must port own coverage

Option 3. Employees may convert Life insurance for employee and dependents (amount as of the employee's last day of work) to an individual policy.

Accidental Death and Dismemberment (AD&D) Coverage

As part of the City's life insurance group policy with The Standard Insurance Company, you are automatically enrolled with AD&D insurance at no additional cost to you if you enrolled in the City's Basic or Supplemental life insurance coverage.

If you lose your life in an accident (or lose your life within 365 days due to injuries from that accident) your beneficiary will be paid an added amount equal to the face value of your life insurance (basic plus supplemental) in addition to your life insurance benefit.

You will be paid one-half (1/2) the face value of your life insurance (basic plus supplemental) if you suffer the loss of one hand, one foot, or the sight of one eye. You will be paid the face value of your life insurance (basic plus supplemental) if you suffer the loss of two or more of the following: hand, foot, or eyesight.

MEDEX Travel Assist

As part of the City's life insurance group policy with The Standard Insurance Company, employees are automatically enrolled with MEDEX Travel Assist at no additional cost if the employee is enrolled in the City's Basic or Supplemental life insurance coverage.

MEDEX Travel Assist is a comprehensive program of information, referral, assistance, transportation and evacuation services designed to help covered employees respond to medical care situations and many other emergencies that may arise during travel. MEDEX Travel Assist also offers pre-travel assistance, which gives the employee access to information like passport and visa requirements, foreign currency and worldwide weather. Employees must be traveling 100 miles or more from home to be eligible for these services.

Beneficiary Designations

Review your life insurance beneficiaries after any major life event (birth, death, marriage, divorce, etc.) to ensure that the appropriate individuals will receive the life insurance benefits. Contact Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285) to change beneficiaries. *Beneficiary Designation* forms are available on-line at the department's Intranet site: www.csj.gov.

When Coverage Terminates

If an employee leaves City employment, he/she may port their current Life and AD&D insurance coverage. If an employee leaves City employment or full-time status ends, the employee may convert their life insurance coverage to an individual whole life insurance policy. The employee **must apply to port or convert their life insurance within thirty-one (31) days** of his/her last day of employment with the City. After thirty-one (31) days, he/she is no longer eligible for this benefit.

LONG TERM DISABILITY (LTD) INSURANCE

City employees are not covered by State Disability Insurance (SDI). Consequently, the City offers two plan options for employee-paid Long Term Disability (LTD) Insurance. Enrollment is voluntary. Long Term Disability is an insurance policy that pays employees up to 66 2/3% of their salary if they become totally disabled on or off the job by an illness, injury, or pregnancy. The City program is offered through The Standard Insurance Company.

Eligibility

All full-time and part-time benefited employees are eligible to participate in this program (temporary employees are not eligible for LTD). Coverage begins on the latter of your date of eligibility or your date of enrollment.

Plan Options

There are two plan options for Long Term Disability insurance, LTD-30 and LTD-60. The following chart shows the differences between the two plan options.

Plan Design	LTD-30 Plan	LTD-60 Plan
Benefit Percentage:	66 2/3% of the first $15,000 of the employee' pre-disability earnings plus 40% of the next $12,500 of the employee's pre-disability earnings, reduced by deductible income.	66 2/3% of the first $15,000 of the employee' pre-disability earnings plus 40% of the next $12,500 of the employee's pre-disability earnings, reduced by deductible income.
Benefit Waiting Period	30 Days	60 Days
Pre-existing Condition Exclusion	None: All pre-existing conditions are covered	12 month exclusion for pre-existing conditions within the 90 days prior to the coverage effective date.
Mandatory Rehabilitation	Not Required	Required

Cost

The current premium cost for LTD-30 is 1.65% of gross bi-weekly earnings and LTD-60 is 1.25% of gross bi-weekly earnings. Premium payments are taken through regular payroll deductions on a bi-weekly basis. These deductions are taken after-tax to ensure that disability payments are not taxable when received.

How to Enroll

Employees have three options for enrollment:

Enroll on-line through the City's Intranet site: www.csj.gov/eway. On-line enrollment is available during the first 30 days after hire or benefits eligibility. No paper forms required.

Complete and return the form provided with your LTD brochure to Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285) within 30 days of the

date of hire. Coverage takes effect on the later of the eligibility date, or date enrolled, provided the employee is actively at work. (See the *Certificate of Insurance*). Coverage is guaranteed if applied for within the first 30 days of hire or benefits eligibility.

Employees may apply for coverage after the first 30 days of employment, however, approval will be subject to completion of a *Medical History Statement* and The Standard Insurance Company's underwriting review. If the employee is approved, coverage will take effect on the date of approval, provided the employee is actively at work.

Detailed Terms and Conditions

The description of benefits in this handbook is for summary purposes only. All terms, conditions, and limitations for these policies are listed in full in the Long Term Disability *Certificate of Insurance* available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285).

Claim Applications

In order to receive Long Term Disability benefits, an employee must submit an LTD claim application within 90 days of the date he/she becomes totally disabled. Contact Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285) for an application packet. The packet includes application instructions, forms, and a *Certificate of Insurance*.

How LTD Insurance Works

Once an employee is approved for an LTD claim, benefits will be payable beginning on the day after the final day of the waiting period during which the employee experienced continuous total disability. Approved claimants will be eligible to receive a monthly benefit of up to 66 2/3% of their monthly wage or salary. For example, if an employee earned $3,000 per month immediately prior to his/her disability, this benefit ensures that he/she will receive $2,000 per month once his/her claim is approved.

Please note that while benefits are payable, any deductible income paid, such as sick leave, is subtracted from the maximum monthly disability benefit.

Deductible Sources of Income

Deductible benefits include sick leave and most disability and retirement income from other sources. These include employer programs (e.g., pensions, as well as paid sick leave), government programs (e.g., state disability, Social Security, or Workers' Compensation), and other group insurance. Other leave payments, including vacation and compensatory time, are **not** deducted from Long Term Disability insurance payments. Employees will receive a minimum LTD payment of $100 per month even if deductible benefits are more than 66 2/3% of the employee's salary.

Definition of Total Disability

During the Benefit Waiting Period (the first 30 or 60 days of continuous, total disability) and for the next twenty-four (24) months, total disability means the complete inability to engage in the employee's regular occupation with the City.

After that, total disability means the complete inability to engage in **any** employment or occupation for which the employee is reasonably qualified, or for which the employee becomes qualified through education, training, or experience.

LTD and Family Medical Leave

Up to the first 12 weeks of the employee's absence due to disability may run concurrent with Family Medical Leave (FMLA) or California Family Rights Act CFRA.

When Payable Benefits Terminate

After a determination is made that the employee is able to engage in any employment or occupation, the Long Term Disability benefit payments will cease. Payments will also cease once the employee reaches the end of the maximum benefit period, or once the program's age limit is reached.

LTD Claims Status

For questions about a claim that has been filed, contact The Standard Insurance Company at (800) 648-1356, or (503) 321-7000.

When Coverage Terminates

Coverage will terminate when an employee leaves City employment, ceases to be eligible, or fails to remit premium. There is no conversion provision associated with this policy.

PERSONAL ACCIDENT INSURANCE

Personal Accident Insurance is available through the City's group policy with the Life Insurance Company of North America. This plan offers full 24-hour-a-day bodily injury protection against accidents anywhere in the world, on or off the job, on business, on vacation, and at home. Illnesses are not covered.

Eligibility

All full-time and part-time benefited employees are eligible for this insurance. Employees may insure themselves, using the Employee Only plan, or they may insure both themselves and family members under the Family Plan if:

The spouse (or domestic partner) is under age 70.

The dependent children (including step, foster, legally adopted children, and children of your domestic partner) are unmarried and less than 19 years old.

The dependent children (including step, foster, or legally adopted children) are unmarried, under age 24, and qualify as full-time students.

No person may be covered more than once under this plan. An employee cannot be covered both as an employee and covered as a spouse, domestic partner, or dependent child of another employee. Dependents are covered at specified percentages of employee's coverage.

Please refer to the Personal Accident Insurance *Certificate of Insurance* available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285) for more detail regarding coverage provisions and exclusions.

Cost

Current cost and benefit information can be found in the Personal Accident Insurance brochure available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285).

How to Enroll

Employees have two options for enrollment:

Enroll on-line through the City's Intranet site: www.csj.gov/eway. On-line enrollment is available within 30 days of hire or benefits eligibility or during open enrollment. No paper forms are required.

Complete the enrollment form available in the Personal Accident Insurance brochure by selecting the amount of coverage that best fits your needs. Be sure to indicate the amount of insurance you want and the plan you want: **Employee Only** or **Family Plan**.

Return the form to Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285).

No underwriting information is required. You are **guaranteed coverage** if you are a benefited employee. Consequently, employees may apply for Personal Accident

Insurance, increase the amount of coverage, or change plan selection at any time without having to obtain approval from the Life Insurance Company of North America.

Personal Accident Insurance Coverage

Payable benefits are determined by the specific nature of the accidental injury or death in accordance with group policy provisions. In general, the following events are all payable at 100% of the maximum benefit for which the participant is enrolled; however, some lesser combination of these tragic events may be payable at less that 100% of the benefit maximum.

Loss of life
Loss of any combination of hands, feet, or eyes,
Loss of hearing and speech,
Quadriplegia

For the employee, the maximum benefit coverage amount is the full amount of coverage elected. For eligible family members, the benefit coverage amount is a percentage of the employee's elected amount. Please refer to this policy's *Certificate of Insurance* for more detail regarding coverage.

Coverage When Flying

The employee and family members are covered while flying (as a passenger only) in any licensed civilian aircraft, or in military transport aircraft operated by Military Airlift Command or similar foreign service. It also covers the employee while he/she is serving as a pilot for pleasure purposes only.

Reductions in Coverage

The employee's coverage is reduced at age 70. Coverage for the spouse terminates when he or she reaches age 70, when the employee's coverage terminates, or when he or she is no longer eligible, whichever occurs first. Coverage for dependent children terminates when the employee's coverage terminates, or when they no longer qualify as dependents.

Identity Theft Program

The employee and family members are automatically covered by the Identity Theft Program if enrolled in the Personal Accident Insurance plan. The Identity Theft Program defends employees against damages caused by identity theft. A personal case manager will assist with advice and select administrative tasks in order to rectify identity theft issues employees may have experienced.

Beneficiary Designations

Review your Personal Accident Insurance beneficiaries after any major life event (birth, death, marriage, divorce, etc.) to ensure that the appropriate individuals will receive the insurance benefits in the case of a qualifying event. Contact Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285) to verify or change beneficiaries. *Beneficiary Designation* forms are available on-line at the department's Intranet site: www.csj.gov.

When Coverage Terminates

Coverage will terminate when the employee leaves City employment, ceases to be eligible, or fails to remit premium. Coverage for the spouse terminates when he or she reaches age 70 or ceases to qualify as a legal spouse. Child dependent coverage will terminate when they cease to be eligible as a qualified dependent (see the *Eligibility* section above).

Policy Conversion

If the employee leaves City employment before he/she reaches age 70, he/she may keep this insurance policy by converting to an individual policy. The employee pays the premium in effect for his/her age and occupation as of the last day of employment with the City. Refer to the Personal Accident Insurance *Certificate of Insurance* available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285) for more information.

LONG TERM CARE INSURANCE

The City offers long term care (LTC) insurance for all benefited employees who are actively at work. The City's LTC insurance plan covers expenses related to nursing home care, residential care, facility care, and community and home based care, and is designed to help alleviate the financial burdens of participants who suffer the need to utilize these services.

Eligibility

In addition to full-time or part-time benefited employees, an eligible employee's spouse or domestic partner, parents, parents-in-law, grandparents, or grandparents-in-law are eligible to apply for long term care insurance under the City's group policy.

Cost

Employees are responsible for the entire portion of their own and their family members' premiums when taken through bi-weekly payroll deductions. Premiums are based on the level of coverage elected and the participant's attained age at the time of application.

Detailed rate information is available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285). Monthly rates are available on-line through the City's custom LTC website (web address and access information cited below). Separate arrangements can be made with Prudential to direct bill for eligible family members if desired.

How to Enroll

Prudential Insurance Company of America administers the City's Long Term Care enrollment process. All applications for enrollment must be submitted to Prudential via mail or on-line when applicable.

- You may order an *Enrollment Kit* on the City of San Jose's custom website:

  Web Address: www.prudential.com/gltc

  Group Name: *sanjose*
  Password: *csjgltc*

- Or, you can contact prudential via e-mail or phone:

  E-mail: LTC.4ME@Prudential.com

  Customer Service Center: 1-800-732-0416

Enrollment Conditions

The following enrollment conditions apply for eligible employees and family members:

New Hires/ Newly Benefited Employee Applications – All eligible New Hires or newly benefited employees will be guaranteed coverage if they apply within the first 90 days of their initial date of eligibility. These employees are eligible to enroll either on-line or through a hard copy application available in Prudential's *Enrollment Kit*.

Late Applications – Employees who chose to enroll after their first 90 days of employment will still be eligible to apply for coverage; however, late applicants will be subject to medical review and approval by Prudential's medical underwriting department.

Please Note: Late applicants must complete Prudential's Enrollment Kit application. Online enrollment is not available for late applicants or eligible family members.

Eligible Family Member Applications – Eligible family members may apply at any time, but must submit *Enrollment Kit* application(s) to Prudential. Each applicant will be required to submit a separate application when requesting coverage. Each application is subject to medical review and approval by Prudential's medical underwriting department.

When Coverage Begins

For late applicants and eligible family members, coverage becomes effective beginning on the first day of the month following the month in which your application was approved by Prudential (it usually takes 1 –2 months to obtain approval).

For New Hires and newly benefited applicants, deadlines for processing applications are applicable and may affect your initial date of coverage. Please contact Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285) for more information about your effective date of coverage.

Basic Plan Options

	Option I Daily Maximum Benefit	Option II Daily Maximum Benefit	Option III Daily Maximum Benefit
Nursing Home Care	$100	$150	$200
Assisted Living or Residential Care Facilities	$75	$112.50	$150
Home & Community Based Care	$50	$75	$100
Lifetime Maximum Benefit Options			
Lifetime Maximum - 5 Years	$182,500	$273,750	$365,000
Lifetime Maximum - 10 Years	$365,000	$547,500	$730,000

Optional Plan Features

Automatic Inflation Option – If you elect this option, your benefits will automatically increase by 5% compounded annually while your premiums remain level based on your original issue age. If you do not elect this option, Prudential will offer you opportunities to increase your coverage over time, but the rates for the increase will be based on your attained age.

Cash Benefit Option - If you elect this option, you will receive benefit cash payments equal to the Home & Community Based Care Daily Maximum you elect without having

to incur formal expenses. The cash benefits you receive can be used at your own discretion.

Exclusions and Limitations

Benefit Waiting/Elimination Period – Before benefits are payable, the participant must satisfy a 90 day waiting period. This period is counted in calendar days and begins on the date that Prudential is contacted to arrange for a claims assessment. This waiting period needs to be satisfied only once during a lifetime.

Pre-Existing Condition Limitation – This limitation applies only to those individuals who are guaranteed coverage without having to satisfy medical evidence (new hires or newly benefited employees). If the participant has a condition for which medical advice or treatment was recommended or received within six months immediately preceding the effective date of coverage, he/she will not be covered for that condition until six months after the effective date of coverage. Please consult Prudential for questions regarding this limitation (further information is available on the website and in the *Enrollment Kit*).

A complete list of Prudential's exclusions, limitations, and disclosures is available in Prudential's Enrollment Kit. Please order an Enrollment Kit even if eligible to enroll on-line.

When Coverage Terminates

Coverage will only terminate for the participant and covered family members if he/she fails to continue to remit premium. If coverage is allowed to terminate, the participant will be required to re-apply for coverage by completing an *Enrollment Kit*. Attaining coverage will be subject to Prudential's underwriting approval. The premium will be re-assessed at the participant's attained age at the time he/she re-applies.

Policy Conversion

If the employee ceases to be eligible as a benefited City employee or separates from City service, he/she may contact Prudential Insurance Company to request direct billing. The premium and coverage will not change. The employee will retain the same plan design afforded to benefited City employees and their eligible family members.

Covered family members may request a direct billing arrangement at any time.

Additional Information

Detailed plan information is available on-line through the City of San Jose's custom website. In addition, the Prudential *Enrollment Kit* contains full plan and disclosure information. To speak with a Prudential customer service representative please call 1-800-732-0416.

Summary plan information and rate sheets are available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285).

DEFERRED COMPENSATION PLAN

This program is a voluntary benefit and provides a convenient way for City employees to save money for retirement. Money is deducted from the employee's payroll check before taxes are taken out (reducing taxable income) and is invested for the employee, per his/her direction through the enrollment process. This program was established under Section 457 of the IRS Code. All City employees are eligible to participate. Once an employee has invested the money, the law does not allow him/her to take it out of the program until he/she retires, terminates employment with the City, dies, or experiences an unforeseeable financial hardship. (See the upcoming section "Financial Hardship" for more information on that subject.) The City also offers a loan provision, by which employees can borrow money from the plan. **This is not a regular savings account.**

Plan Description

The Deferred Compensation Plan is a written agreement between the employee and the City. It allows employees to defer and invest part of their wages, and not pay taxes on this money until the money is received. At that time, presumably, the employee will be in a lower tax bracket and will therefore pay less tax on the money than if it was received now in the employee's present tax bracket.

Deferred Compensation Plan Advantages

The program also allows the interest on the employee's invested money to accumulate tax-free until the money is distributed to the employee. This deferral of taxes allows employees to invest more money than they could afford to invest if they used after-tax dollars for savings. It also allows the earnings on an employee's investment to accumulate faster than it would if it was taxed in the year it was earned. The complete text of the Deferred Compensation Plan can be found in Chapter 3.48 of the San Jose Municipal Code.

In the long term, this program helps employees to:

Reduce current tax liability.

Accumulate more money than is usually possible with after-tax savings methods.

Supplement retirement income. This program does not affect employees' City Retirement System program or contributions in any way. By participating, however, employees can supplement the amount of money they will have to spend during retirement.

Investment of Your Deferred Wages

An Advisory Committee manages the investments of deferred wages. This committee establishes contracts with companies offering appropriate investment vehicles. Employees may request that their money be invested in a particular area. However, the final determination of investment vehicles available at any given time is made at the sole discretion of the Advisory Committee.

Employees' deferred income is placed in an account established for them with the administrator they have selected. All payroll deductions and interest earnings are

credited to the account. All assets are held by the City in trust for the exclusive benefit of the participants and beneficiaries of the plan.

Maximum Amount of Deferral

Under federal law, the **maximum** amount that may be deferred in calendar year 2007 is $15,500. This **maximum** will increase $500 annually thereafter. Contributions can be 100% of gross compensation or a dollar limit not to exceed the contribution in effect for the current year. The **minimum** amount that may be deferred is $25 per pay period.

Pre-Retirement Regular Catch-Up Provision

There is an exception to the maximum limitation rule. During the three (3) years before the year designated as the employee's normal retirement age, he/she may exceed the maximums described above in order to make up for years when he/she did not invest the maximum amount for which he/she was eligible. This is called the Regular Catch-Up Provision.

Catch-Up Rules

Catch-Up Provision rules are as follows:

1. The employee may defer the difference between what he/she was eligible to defer and what was actually deferred from January 1, 1979, to the present.

   A calculation is required to determine eligibility for this provision. Please contact Deferred Compensation in Human Resources (City Hall Wing, 2nd Floor, 975-1465) for further information.

2. The total annual deferral during the Catch-Up period may not exceed twice the normal annual contribution limit in effect for the current year. The Catch-Up limit for 2007 is $31,000. In 2008 and later the annual maximum will be a cost of living increase in $1,000 increments. This includes the maximum amount employees are allowed to defer during the current year, plus the eligible Catch-Up amount.
3. Regular Catch-Up can begin three years prior to normal retirement age.

Catch-Up Provision for Employees Aged 50+

Individuals who are currently age 50 or older, or who will turn age 50 in the calendar year, may contribute an additional $5,000, for a total of $20,500 for 2007. In 2008 and later the annual maximum will be a cost of living increase in $500 increments. Participants may not use this provision if they are using the above Regular Catch-Up Provision.

Deferred Income Investment Options

Employees have several choices for investing their deferred income. Contact Deferred Compensation at (408) 975-1465 or the ING local office at (408) 881-0110 for details. Employees may transfer their money between investment options at any time.

How to Enroll

Employees have three options for enrollment and may enroll anytime during employment:

Enroll on-line through the City's Intranet site: www.csj.gov/eway. This option is only available within 30 days of the date of hire. No paper forms are required.

For individual appointments, brochures and program details, contact Deferred Compensation in Human Resources (City Hall Wing, 2nd Floor, 975-1465) or the ING local office at (408) 881-0110.

Meet with the ING provider representative, who is available in City Hall every Wednesday from 9:00 to 3:00 and certain other locations at scheduled times. Call the ING local office at (408) 881-0110 for the current schedule.

Making Per Paycheck Deferral Changes

Paycheck deferral amounts can be made on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required.

Payroll check deductions for deferred compensation will begin according to the IRS "first-of-the-month" rule. The "first-of-the-month" rule requires that a participant, requesting a first time deferral, an increase of deferral or restart of deferral, makes the election before the first of the month in which the deferrals occur. Therefore, elections entered or submitted, between the 1st and last day of the month, will be deferred from paychecks in the following month.

NOTE: If the contribution is being changed to zero, the first-of-the-month rule does not apply, and the deduction will be effective within two (2) paychecks.

Distribution Options

Under certain circumstances, the value of the account may be distributed to the employee as the employee elects. If the employee leaves the City to work for another employer in the State of California who has an eligible 457 deferred compensation plan, the employee may elect to transfer his/her funds to the new employer. See the section on "Pay-Out Options" for more information.

Here are some of the reasons a distribution may be requested:

- Death (payment to beneficiary)
- Retirement
- Separation from City service
- Financial hardship (See the upcoming section "Determination of Financial Hardship" for more information on this subject.)

- Residential and General Purpose Loans (See the upcoming section “Loan Provision” for more information on this subject.)

Within thirty (30) days following separation from of City employment employees must decide how to proceed with their deferred compensation balance. Employees may not receive funds in the same month that they separate from service.

Determination of Financial Hardship

Employees may withdraw funds from their deferred compensation account prior to retirement only in some cases of financial hardship. Section 457 of the Internal Revenue Code defines financial hardship as the "occurrence of an unforeseeable emergency" that causes severe financial hardship to the employee or his/her dependents and is not covered by other insurance. It also states that financial hardship is not intended to include the use of funds to purchase a home or send children to college.

Financial Hardship Withdrawal

To apply for a hardship withdrawal, contact ING’s customer service number at (800) 584-6001.

Loan Provision

There are two types of loans available: General Purpose and Residential. General Purpose loans can be used for any reason and have a maximum repayment period of 5 years. Residential loans must be used for the purchase or renovation of your primary residence and have a maximum repayment period of 20 years. The City’s loan program allows for a maximum of one of each type of loan to be outstanding at any one time. The minimum loan amount is $1,000 and the maximum loan amount is 50% of the employee’s account value or $50,000, whichever is less.

To request a loan, contact ING’s customer service number at (800) 584-6001.

Income Tax Rules

The money deferred, and the income earned on this money, is subject to income tax at the time the money is received. Under current IRS regulations, distributions from Deferred Compensation **may** be "rolled over" into an IRA, 403(b), 401(a) and/or 457(b) governmental Deferred Compensation plan.

Pay-Out Options

Employees may choose to have their benefits paid to them in one or more of the following ways:

- A single lump sum.
- Partial Distribution.
- In equal monthly, quarterly, semiannual, or annual installments of $50 or more, over a pre-selected period.

- Various lifetime annuity options (see the enroller for details). Fractional Payments.
- Postponement of payments until a future date, not beyond age 70 1/2. After postponement, employees select from the options listed above.

If payment is not delayed, payment of benefits may start as soon as thirty-one (31) days after termination of employment, but no later than sixty (60) days after the end of the calendar year in which the employee terminates employment.

Post-Retirement Earnings

The employee's retirement account will continue to earn interest after retirement (unless all money in the fund was withdrawn in a lump sum at the time of retirement).

If a "pre-selected period" pay-out is chosen, the enroller will calculate the projected growth of the account at anticipated interest rates based on the length of the pay-out period selected. This calculation will be used to establish the amount of the payments received from the account. Any excess earnings due to higher-than-anticipated interest returns after retirement will increase the payment amount received.

If you choose a "pre-selected amount" pay-out, the amount of each payment will not change, but the length of the pay-out period may vary. Any excess earnings due to higher-than-anticipated interest returns after retirement will extend the number of payments you receive.

Beneficiary Designations

Beneficiary designations on deferred compensation accounts should be reviewed after any major life changes. The City's ***Beneficiary Designation*** form supersedes wills, so designations should be kept current at all times.

If the employee is married and his/her spouse was not named as beneficiary, the spouse may have community property rights to the account funds unless the spouse signs an acknowledgement that he or she is not a beneficiary.

BENEFITS CONTINUATION DURING LEAVES OF ABSENCE

Paid Leaves of Absence (LOA)

Benefits eligibility is established through regular paycheck premium deductions taken each payperiod. If an employee is on a paid leave of absence (sick leave, vacation, Workers' Comp case, etc.) and continues to receive a City paycheck, both the employee's and the City's premium contributions will continue to be made on his/her behalf to the City's respective benefit providers. Consequently, employees on paid leaves of absence do not need to do anything to maintain their benefits eligibility while out on a paid LOA.

Unpaid Leaves of Absence

When an employee begins an unpaid leave of absence, City paychecks will cease. Consequently, the employee and City portions (if applicable) of the premium contributions will stop. This lack of premium contribution will interrupt your benefits eligibility within both the City's and the benefit providers' systems.

Beginning an Unpaid Leave of Absence

As soon as going on unpaid leave is anticipated (even while on a paid leave of absence) contact Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285) for information regarding premium/benefits continuation. Employee Benefits will provide information to assist employees with continuing benefits so that no break in coverage is experienced.

Benefits Continuation Limitations

Some of the City's benefit plans and policies contain provisions for maximum leave periods. Please refer to the *Benefits Continuation Matrix* to identify which benefit plans have maximum leave limitations. Employees will not be permitted to continue these benefits beyond the maximum LOA period permitted by the City's policies or contracts, regardless of the employee's willingness to continue to remit premium.

Benefits Continuation While on Family and Medical Leave (FMLA)

While on an approved Family and Medical Leave, employees will be entitled to the City's regular contribution to Health, Dental, Vision (if applicable) and EAP benefit premiums for the 12 weeks of leave allowed by FMLA legislation (See the *Family and Medical Leave (FMLA)* section on page 57).

While on paid FMLA leave, the employee's and the City's premiums will be collected and remitted as usual through regular paycheck deductions. If and when an unpaid FMLA leave begins, employees will be responsible for remitting their portion of the regular premium; the City will continue its portion through the remainder of the 12 weeks of FMLA leave.

Additional Information

Each leave of absence is somewhat different. Contacting an Employee Benefits staff member prior to beginning of an LOA is recommended. More information is available from Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285).

TIME OFF: PAID AND UNPAID

HOLIDAYS

All eligible full-time employees receive fourteen (14) paid holidays per year. These holidays are:

New Year's Day	Columbus Day
Dr. Martin Luther King	Veterans' Day
Presidents' Day	Thanksgiving Day and
Cesar Chavez Day	The day after Thanksgiving
Memorial Day	Christmas Eve Day
Independence Day	Christmas Day
Labor Day	New Years Eve Day

Note: Selected City offices and facilities are closed to the public during the holiday furlough (the days between Christmas and New Years Eve). Essential services including, but not limited to, Police, Fire, Airport, and Environmental Services/WPCP will continue to operate and certain scheduled recreational and cultural facilities and events will be held as scheduled. Department Directors will determine which services will remain open. City employees are asked to participate in the closure on a **voluntary** basis. If working during the closure is preferred, employees must notify their supervisor in advance to make arrangements for an assignment. Employees may be assigned to perform work outside of their usual assignment and possibly outside of their department.

During the closure, some work days do not fall on holidays. For these days employees should record their time off as vacation, personal leave, compensatory time or executive leave, if paid leave is desired (sick leave may not be taken).

Holiday pay is calculated by the number of hours for which the employee is regularly scheduled to work. Specified employees may receive pay in lieu of holiday time off. Holiday dates are published in a City Calendar that is distributed to all employees before the beginning of each year.

VACATION

Consult the applicable MOA or Benefit and Compensation Summary for information about the vacation time that employees earn each year that they work for the City and the amount of unused vacation that may carry over at the end of each year or the vacation accrual maximum. If an employee leaves City employment prior to the end of the year, he/she may owe the City for vacation hours that were used but not yet earned.

Depending on the applicable MOA or Benefit and Compensation Summary, a certain number of hours may be carried over from one calendar year to the next. Rules vary for management employees, non-management employees, and public safety employees. Under certain conditions the City Manager may authorize exceptions. Consult the Office of Employee Relations (535-8150) for specific details.

For employees working part-time, on a reduced workweek, or taking time off without pay, their vacation accumulation is affected, because vacation time is calculated by the number of hours for which they are paid. Please note that employees do not accumulate extra vacation time for overtime hours worked.

PERSONAL LEAVE

Some full-time employees may also take personal leave, subject to supervisor approval. Consult the applicable MOA or Benefit and Compensation Summary to learn if you are eligible for Personal Leave.

SICK LEAVE

All full-time employees may take sick leave with pay as medically required. Sick leave is for injuries or illness, and for routine health and dental appointments. Employees may take sick leave to care for a sick dependent. Check the applicable MOA or Benefit and Compensation Summary for details.

Employees must contact their supervisor before their scheduled work shift begins to advise them of the need to use sick leave. Substantiation (such as a doctor's certificate) may be required for any sick leave.

Paid sick leave accrues at a rate of approximately one (1) hour per twenty-two (22) hours worked up to a maximum of 96 hours per year for most employees. There are no carryover limits. For employees working part time, on a reduced workweek, or taking time off without pay, their sick leave accumulation is reduced because sick leave time is calculated based on the number of paid hours. Employees do not accumulate extra sick leave for working overtime hours.

Employees retiring after fifteen (15) years of service, or more, may receive pay for a percentage of their unused sick leave. Check the applicable MOA or Benefit and Compensation Summary for more information.

BEREAVEMENT LEAVE

Full-time or part-time benefited City employees may be eligible for paid leave in the event of the death a relative.

The employee's supervisor may request verification for bereavement leave. Bereavement leave for a brother-in-law, sister-in-law, or domestic partner in lieu of a spouse may be authorized in the MOA or Benefit and Compensation Summary. Bereavement leave is not paid if an employee is not scheduled to work. For details, consult the applicable MOA or Benefit and Compensation Summary.

JURY DUTY LEAVE

Employees serving as jurors will receive their regular pay; however, if employees receive jury fees, they must remit them to the City. Employees may keep their mileage payment.

WITNESS LEAVE

Each full-time employee of the City who is required, under subpoena, to take time off duty with the City, to appear as a witness, by reason of their employment with the City, in any case or proceeding in any Court of this State or of the United States of America, shall receive their regular salary during the term of their service as a witness under subpoena, less any and all witness fees which the employee may receive therefore. Compensation will not be paid if the employee is a party to a state or federal action.

Please see the applicable MOA or Benefit and Compensation Summary for specific details.

MILITARY LEAVE

Please refer to City Policy Manual Section 4.2.2 located on the City's Intranet site at www.csj.gov on the Employee Relations web page.

FAMILY AND MEDICAL LEAVE (FMLA)

Under the federal Family and Medical Leave Act of 1993, (FMLA) employees may be entitled to unpaid leave with the City's portion of the health and dental premiums paid for **if:**

The employee has worked for the City for at least one year, and has at least 1,250 hours of work time (excluding paid leave) in the preceding 12 months; and

The leave is for one of the following reasons:

1. To care for a new child through birth, adoption, or state-enacted foster care; or
2. To care for a seriously ill child, spouse, or parent who requires hospitalization or continuing treatment by a physician; or
3. To treat the employee's own serious medical condition which makes him/her unable to work; and

The employee uses all of his/her available sick leave (when applicable) and all of his/her available personal or executive leave, as part of the FMLA leave.

How to Apply for FMLA Leave

To request FMLA leave, complete the *Family and Medical Leave Application,* and a *Request for Leave of Absence* form. The employee's Timekeeper has both forms and can assist with completing them. Apply for FMLA leave before the leave begins if possible. FMLA leave will not be approved after the FMLA entitlement period ends (FMLA entitlement period is limited to 12 weeks per year).

How much FMLA Leave can be taken?

The combined total of paid and unpaid leave for family medical leave purposes under the FMLA is limited to twelve (12) weeks per 12-month period.

Pregnancy Leave: FMLA and PDLA

If an employee is disabled by her pregnancy, by childbirth, or by related medical conditions, she may be eligible for up to sixteen (16) weeks of leave, in addition to her FMLA leave, under the California Pregnancy Disability Leave Act (PDLA). As with any unpaid leave other than FMLA-entitled leave, the employee must pay the full cost of the health and dental premiums in order to continue health and dental coverage during leave under the PDLA.

The City's portion of the health and dental premium costs will only be paid during the paid and unpaid portion of the employee's approved FMLA leave. If the employee's department approves unpaid leave beyond the FMLA leave entitlement, the employee is responsible for the full cost of health and dental premiums (employee's portion and the City's portion) during this additional leave.

The employee will be advised in writing of the authorized leave period under the FMLA after review of the application and receipt of the required medical verification.

Medical Verification is Required for FMLA Leave

For FMLA leave, medical verification is required from the employee's health care provider that he/she is unable to perform the functions of his/her job or is needed to care for a family member. The FMLA medical verification must contain the following:

For FMLA leave for the employee's own illness or injury:

Doctor's certification of the employee's "serious medical condition" as described in the federal Family and Medical Leave Act; the approximate date the medical condition began; the probable duration of the condition; the probable duration of the inability to work due to the condition; certification that the employee is unable to perform one or more of the essential functions of their job.

For FMLA leave to care for an eligible family member:

Doctor's certification of the same information described above regarding the employee's family member's illness or injury; the doctor's statement that he/she must be absent from work to care for this family member; the description of the care the employee will provide; and estimate of the period during which this care is required for the family member (including the anticipated work schedule if the leave will be taken on an intermittent basis to care for a family member).

Medical verification for FMLA leave must be provided directly to the Return to Work Coordinator, Human Resources, City of San José, 200 E. Santa Clara St., San José, CA 95113. Because this information is confidential, it should not be attached to the *Family and Medical Leave Application*. A medical verification form is available from the department Timekeeper (or Human Resources) for the employee and his/her doctor to use in providing the medical certification required for FMLA leave.

A "Doctor's Note" is generally not sufficient to provide FMLA medical verification. FMLA medical verification is separate from and in addition to any statement or form which may be required for any insurance purpose including a claim for Long Term Disability Insurance provided by The Standard Insurance Company. Leave under the FMLA will not be approved until the FMLA medical verification has been received by Human Resources.

LEAVE OF ABSENCE WITHOUT PAY

Employees may be able to take a leave of absence without pay subject to the approval of their supervisor, their department head, and the Director of Human Resources. This type of leave may be used for any valid reason, including taking time off to spend with a new baby.

How to Apply

To request a leave of absence, or take more than two weeks off without pay, an employee must fill out a *Request for Leave of Absence* form, available from the Department Timekeeper. **Note:** A separate application is required when applying for Family and Medical Leave (FMLA).

Insurance while on Unpaid Leave

While on any kind of unpaid leave (other than approved Family and Medical Leave under the Family Medical Leave Act of 1993) employees must pay for the City's contributions to their health and dental premiums, as well as making their own usual contributions.

While on any unpaid leave, including unpaid leave under the Family and Medical Leave Act of 1993, employees must pay their own and the City's contributions for any other insurance coverage, such as life insurance or long term disability to continue their coverage. Employees must pay all of the necessary premiums during any unpaid leave to keep their insurance coverage in effect. The City does not automatically make its contribution to employees' insurance programs while they are on unpaid leave. If these payments are not made, coverage will lapse.

Contact Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285) for more information regarding benefits continuation while on unpaid leave.

Vacation, Sick Leave, and Service Credit while on Unpaid Leave of Absence

When an employee takes a leave of absence without pay, the following items, determined by the number of hours he/she works, are affected as follows:

- Vacation, sick leave, retirement service hours, and seniority hour balances cease to accumulate.
- The timing of step increases is delayed.
- Completion of probation is delayed.

LOA Extensions

Any extension to a leave of absence must be requested in writing prior to the end of the employee's leave.

End of LOA

Failure to return to work immediately following the end of an approved leave of absence will be considered a voluntary resignation.

SICK LEAVE WITHOUT PAY

Full-time employees may be eligible for unpaid leave for an absence due to a non-job-related illness, injury, or disability. This is considered *Sick Leave Without Pay*.

See the applicable MOA or Benefit and Compensation Summary for specific limits on the length of sick leave for your position. *Sick Leave Without Pay* is one example of *Leave of Absence Without Pay*, and all *Leave of Absence* procedures are applicable.

RETURNING FROM A LEAVE OF ABSENCE

When employees return from a leave of absence, they must complete a *Return from Leave Verification* form and turn it in to their Department Timekeeper. Employees will not be paid until this form has been completed.

If coverage has been dropped from any City benefit plans because the employee did not pay his/her own premiums during their leave, the employee may be required to re-enroll upon his/her return from leave. Coverage will begin again once the appropriate premiums are paid, but no sooner than the first of the month following the return from leave. Please contact Employee Benefits in Human Resources (City Hall Wing, 2nd Floor, 535-1285) for more information.

TIME DONATION PROGRAMS

CATASTROPHIC ILLNESS/INJURY TIME DONATION PROGRAM (CITD)

This provision is designed to assist an employee who has exhausted paid leave time due to the employee's critical medical condition or, depending on the bargaining unit, critical medical condition of an eligible family member. This provision allows other employees to donate time in accordance with the following terms so an employee may continue in a paid status with the City for a longer period of time.

Please refer to the applicable MOA for union-specific requirements. Also, please consult City Policy Manual (CPM), Section 4.2.10, *Time Donation Programs,* for more details regarding policy and administrative procedures. The CPM can be found on the City's Intranet site under the Employee Relations Department.

PERSONAL ILLNESS/INJURY TIME DONATION PROGRAM (PITD)

This provision is designed to assist an eligible City employee who has exhausted paid leave time due to employee's non-critical medical condition. This provision allows other employees to donate time in accordance with the following terms so an employee may continue in a paid status with the City for a longer period of time.

Please refer to the applicable MOA for union-specific requirements. Also, please consult City Policy Manual (CPM), Section 4.2.10, *Time Donation Programs,* for more details regarding policy and administrative procedures. The CPM can be found on the City's Intranet site under the Employee Relations Department.

CANCER SCREENING RELEASE TIME PROGRAM

The City has implemented a Cancer Screening Release Time Program. The purpose of this program is to allow City of San José Civil Service employees (classified and unclassified) time away from work to receive breast and prostate cancer screening. Because early detection and diagnosis of such cancers can save lives, the goal of the City of San José is to encourage its employees to schedule and receive regular breast and prostate screenings through their health care provider in order to increase the benefits of prompt treatment.

Please refer to City Policy Manual (CPM) Section 4.2.13 for more information. The CPM and the Cancer Screening Release Time form can be found on the City's Intranet site under the Employee Relations Department.

WORKERS' COMPENSATION

IT'S THE EMPLOYEE'S RESPONSIBILITY TO REPORT ON-THE-JOB INJURY OR ILLNESS

An employee who is injured on the job must report it to his/her supervisors (or the next level in chain of command) immediately. If time could be lost from work, a physician should be seen within 24 hours. California law provides benefits to employees who are injured on the job or contract a job-related illness. Benefits vary with each situation. Employees should keep their supervisor aware of their current status.

What is Workers' Compensation?

California workers' compensation law, passed by the state Legislature more than eighty-five years ago, guarantees prompt, automatic benefits to workers injured on the job.

Who is Covered?

All City employees are covered under workers' compensation law. Unpaid volunteers may not be covered.

What is Covered?

Any injury or illness caused by your job is covered—everything from first-aid type injuries to serious accidents. Job-related illnesses may qualify for workers' compensation coverage as well.

Workers' Compensation Benefits and Payments

For a complete description of workers' compensation benefits and payment information, please consult the "*Facts for Injured Workers*" brochure included with new employee enrollment materials.

For More Information

Visit Workers Compensation: Human Resources, Workers' Compensation
City of San Jose
200 E. Santa Clara St., 2nd Floor Wing
San Jose, CA 95113-1905

Or, call Workers' Compensation: (408) 535-1285

EMPLOYEE DEVELOPMENT

TRAINING AND DEVELOPMENT

All City employees are encouraged to take advantage of the training and development opportunities offered by the Performance Development Division of Human Resources. Training classes include over 200 courses offered in subjects such as Analytical Skills, Career Development, Personal Leadership Skills, City Operations, Citywide Issues, Communication Skills, Retirement Planning, Safety, Wellness, and Computer Skills. These courses are designed to develop current job skills, to foster career development, and to enable personal well being. To view the training classes and register, visit the City's Performance Development Intranet site at www.csj.gov.

Additional training and development opportunities include supervisor training, certificate programs, and an accelerated Associate of Arts degree partnership with City College and Evergreen Valley Community College District. Contact Performance Development at 535-1285 for more information.

EDUCATIONAL REIMBURSEMENT (NON-MANAGEMENT)

This program is intended to encourage employees to further their outside academic, professional, and technical education to enhance career development and performance with the City of San José. The City provides financial assistance to employees who complete educational work that enhances their career development with the City of San José. Full-time and part-time benefited employees with at least six months of service are eligible to take advantage of this benefit. Consult City Policy Manual Section 4.3.1 and the applicable Bargaining Unit's Memorandum of Agreement for specific benefits, available online at http://www.csj.gov/oer/moa.asp. Contact your Department Training Liaison or Employee Relations at 535-8150 for current procedures.

EDUCATION BENEFITS FOR MANAGEMENT EMPLOYEES

Management employees also have educational incentive benefits. Details about these benefits are available from Employee Relations at 535-8150 or in the applicable MOA or Benefits and Compensation Summary which is also available on the intranet at http://www.csj.gov/oer.

ALTERNATIVE WORK SCHEDULES

ALTERNATIVE WORK SCHEDULE PROGRAM

The Alternative Work Schedule program allows certain employees to request a biweekly work schedule other than the normal schedule of five 8-hour days each week. Applications are available from the Department Timekeeper or the Office of Employee Relations.

An Alternative Work Schedule is subject to approval by the Department Head and Office of Employee Relations, and is intended to be the employee's permanent schedule, although it may be terminated or revised to meet the employee's changing needs or the needs of his/her work unit. Consult the applicable MOA to see if the Alternative Work Schedule program is available to you and the City Policy Manual Section 4.2.11 Alternative Work Schedules for more specific information.

REDUCED WORK WEEK PROGRAM

All employees except police and fire (sworn) personnel may request a reduced work week for personal or medical reasons. The employee's department has complete discretion regarding approval unless a documented medical condition is the reason for the reduced work week request.

The City's contribution for premiums for health, dental and life insurance are prorated from the amount contributed for full-time employees, based on the number of work hours scheduled per week under each individual reduced work week agreement. Applications and additional information are available from Human Resources (City Hall Wing, 2nd Floor, 535-1285). Please refer to City Policy Manual Section 4.2.12-Reduced Work Week Schedules for more specific information.

COMMUTE ASSISTANCE PROGRAMS

ECO PASS PROGRAM

What is an Eco Pass?

The Eco Pass is an annual, photo ID pass that entitles eligible City of San Jose employees to ride on any Santa Clara Valley Transportation Authority (VTA) bus or light rail line seven days a week and 24-hours per day at no cost to the employee.

Who is eligible for an Eco Pass?

All full-time and part-time benefited employees of the City of San Jose are eligible for an Eco Pass.

How can I obtain an Eco Pass?

Eligible employees can obtain their Eco Pass card by visiting the VTA's Downtown Customer Service Center.

No appointments are necessary. Walk-in photos are taken at the following location and times:

VTA Downtown Customer Service Center
2 North First Street
San Jose, CA 95110

Monday – Friday: 8:00am – 6:00pm
Saturdays: 9:00am – 3:00pm

During your visit you will be required to furnish a *FT/PT Benefited Employee Eco Pass Authorization* form provided by Human Resources or other proof of employment. Contact the Transportation Planning Division, (408) 535-3850, if you have questions. Your photo will then be taken by a VTA customer service representative who will have your Eco Pass card sent to your work location in approximately 2 weeks.

How can I replace an Eco Pass?

For the first incident, employees are required to pay a $25.00 fee to replace a lost Eco Pass or a $5.00 fee to replace a stolen pass (when the employee furnishes a copy of a Police report). A $50.00 fee is required to replace a lost or stolen Eco Pass for any subsequent incidents.

Eco Pass Replacement Forms are available from your Department's Commute Assistant. Employees must send in the appropriate fee to the VTA address on this form. Checks should be made payable to the "Valley Transportation Authority."

COMMUTER CHECK PROGRAM

What are the program goals?

The Commuter Check Program is designed to encourage public transit use by City of San Jose employees. The intended benefits for participating in the program include traffic congestion relief, reduced parking demand, and improved air quality.

How does the program work?

The Commuter Check Program provides employees with a $20 per month transit subsidy for all Bay Area transit services, including:

Caltrain
Altamont Commuter Express (ACE)
BART
Highway 17 Express Bus
SMART Bus

Each of the transit organizations listed above will recognize the $30 redeemable voucher when an employee submits it for the purchase of multi-ride or monthly passes. The employee pays $10 for the Commuter Check, but receives a $20 benefit.

The Commuter Check entitles the bearer to a $30 credit towards the purchase of their multi-ride or monthly transit passes.

Who is eligible?

Unlike the Eco Pass Program, the Commuter Check Program is available to all Full and Part-time benefited and unbenefited employees alike.

Where can I purchase a Commuter Check?

You may purchase your Commuter Check at the following location and times:

Department of Transportation
Transportation & Parking Operations Division
San Jose City Hall Tower, First Floor, Window #7

Monday – Friday: 8:00am – 5:00pm

EMERGENCY RIDE HOME PROGRAM

How does the program work?

The Valley Transportation Authority (VTA), through the Eco Pass Program, has an account with the Yellow Checker Cab Company and will pay for an emergency-only ride home for any employee who requests the service the same day he or she used bus or light rail to get to work.

What constitutes an emergency?

Qualifying emergency situations include:
- Illness to the employee or an immediate family member
- Unscheduled overtime requested by a supervisor/ manager

The Emergency Ride Home program may not be used for errands, pre-planned medical appointments, business-related travel, un-authorized overtime, or missed or late transit.

How can employees take advantage of this benefit?

Employees interested in utilizing the Emergency Ride Home program must work with their supervisor or manager to access the benefit:

- The employee is required to verify for their supervisor/manager that they rode VTA Bus or Light Rail on the day of the request.
- The employee's supervisor or manager should contact the Department of Transportation's Transportation Planning Division at (408) 535-3850 for an *Emergency Ride Home Voucher* form (to be filled out by the supervisor/manager).
- It is the supervisor or manager who is responsible for arranging the ride home with the Yellow Checker Cab Company.

For more information about the Emergency Ride Home program, contact the Transportation Planning Division at (408) 535-3850.

ALTERNATIVE TRANSPORTATION OPTIONS

Bike Parking

Secure employee bike parking is available at City Hall and the Employee Health Building. Employee bike parking consists of individual bike lockers and an enclosed bike cage. Advance registration is required. To access the employee bike parking facilities, contact John Brazil in the City's Bicyclist & Pedestrian Program at (408) 975-3206.

Vanpooling

The City of San Jose's Commute Assistance Program (CAP) is working with the Enterprise Rideshare Program to offer vanpooling to City employees.

The Enterprise Rideshare Program, a division of Enterprise Rent-A-Car, specializes in leasing full-size vans and mini-vans to groups of co-workers that are tired of the hassle and expense of driving their own cars to work each day. For more information contact the Transportation Planning Division at (408) 535-3850.

PERSONAL BANKING SERVICES

DIRECT DEPOSIT OF PAYCHECKS

All permanent full-time and part-time employees may have their payroll checks automatically deposited into their own bank account through the City's Direct Deposit program. Some of the advantages of direct deposit include:

No long bank lines

No possibility of losing your check

Deposits take place even if you are sick or on vacation

How Direct Deposit Works

Any Automated Clearing House (ACH) member bank may be used. Nearly all banks are eligible to receive direct deposits. Employees can sign-up for multiple bank accounts on-line.

To start direct deposit employees have two options:

Sign-up on-line through e-Way on the City's Intranet site at www.csj.gov/eway. On-line sign-up usually takes effect immediately.

Fill out an *Employee Authorization for Automatic Deposits* form and return it to Payroll with a copy of your bank deposit slip. Depending on when Payroll receives your request, the direct deposit of your check may not begin until the following pay period.

To add and/or close an account, and change banks, use one of the options above to effect the changes immediately.

Deposits will be posted to the employee's bank account on each pay day.

Although the earnings go directly to the bank, employees will receive an earnings and deductions statement with the same information those employees who receive a paper paycheck receive. Paper statements are printed and distributed by Payroll. However, in-lieu of receiving paper statements employees can also view and print this information on-line through e-Way on the City's Intranet site at www.csj.gov/eway . Use the Direct Deposit menu in e-Way to stop the printing and distribution of your paper statements by Payroll.

An employee's Direct Deposit is not automatically deactivated upon termination of employment with the City, or during extended leaves of absence. Any payoff of unused leave balances such as accrued vacation, compensatory time, and any sick leave pay to which an employee is entitled will be automatically deposited into the employee's active direct deposit account.

If an error is discovered in the employee's pay, a deposit correction may be made within 5 days. If an employee is underpaid, he/she will be issued a supplemental payroll check.

Employees may enroll or cancel at any time.

SAN JOSÉ CREDIT UNION

Any full- or part-time City employee, active or retired, and their family members, can join the San José Credit Union.

Credit Union Services

For many employees, the San Jose Credit Union serves as the single source for all of their deposit account services. Some of the services that the San Jose Credit Union offers are as follows:

- Share (Savings) Accounts
- Certificate Accounts
- Share Draft (Checking) Accounts
- Individual Retirement Accounts (IRA's)
- Loans to Go
- Payroll Deduction
- Credit Life & Disability Insurance
- Visa Credit Card
- Visa Check Card
- Automatic Teller Machine (ATM)
- Teller Phone Audio Response
- Group Family Protection Plan
- Auto and Homeowners Insurance

For More Information

Please contact the San José Credit Union (SJCU) directly if you are interested in becoming a member or have any questions regarding available services:

SJCU Main Branch
140 Asbury Street
San Jose, CA 95110
(408) 294-8800
www.sjcu.org

SJCU 4th Street Branch
88 South 4th Street
San Jose, CA 95112
(408) 294-8800
www.sjcu.org

SANTA CLARA COUNTY FEDERAL CREDIT UNION

All full- or part-time City employees, active or retired, their family members and volunteers of, are invited to take advantage of County Federal membership eligibility.

County Federal is the rare, Traditional Credit Union, serving select employer groups. As a full service financial institution, County Federal membership includes the following:

- Free Savings
- Free Rewards Checking
- Free On-line Banking
- Free On-line Bill Pay Service

- Free Co-Op ATM Access
- Free 24-Hour Telephone Transaction System
- Free Financial Seminars
- Free Car Shopping Service to simplify the car buying process
- On-Site Car Sales
- Direct Deposit
- Visa® Credit and Check Cards
- Consumer and Real Estate Loans
- Home Equity Lines of Credit
- Certificate Accounts
- Money Market Account
- Individual Retirement Accounts (IRAs)*
- Holiday and Summer Pay Vacation Club Accounts**
- Looney Tunes Youth Account
- boom! Teen Club Account
- Student Scholarships
- Discounted Amusement Park Tickets
- Multiple Branch Locations
- Saturday Hours at select Branch Locations

For more information or to find a branch closest to you, please visit County Federal at www.sccfcu.org or call (408) 282-0700.

San Jose Main Branch	City Centre Branch
852 N. First Street	140 E. San Fernando St.
San Jose, CA 95112	San Jose, CA 95112

* Continuous contributions allowed through Direct Deposit to a 6 or 12 month termed IRA certificate.
** Holiday and Summer Pay Vacation Accounts pay .25% higher dividends than the regular savings rate.

U.S. SAVINGS BOND PROGRAM

This program allows City employees to save money by purchasing United States Savings Bonds for their children's college education, for an emergency fund, or for their own retirement.

Employees can sign up to have money withheld from their payroll check to be used to purchase savings bonds. Any full-time City employee may participate in this savings program.

Bonds cost one-half their face value. For example, a $100 bond costs $50. At maturity, it will be worth $100.

Bond Registration

No more than two names can appear on any one bond as owner. Employees have three options for bond registration (ownership):

1. Single ownership in the name of one adult or one minor.

2. Co-ownership in the names of two people as co-owners. Either person may redeem the bond at any time.
3. Beneficiary, with one person as owner and another person as beneficiary. The beneficiary may redeem the bond only after the death of the owner.

Payroll Deduction Options

To purchase savings bonds, employees must first decide how much they want deducted from each payroll check, and which bond denomination they want. The smallest bond available through payroll deduction is the $100 (face value) bond. Other available denominations include $200, $500 and $1,000.

It is not necessary to purchase a bond every payday; employees may have deductions in lesser amounts withheld each payday until enough to purchase a bond has been withheld. For example, to purchase a $100 bond (cost: $50), employees may have $5 deducted from their payroll check for ten (10) pay periods, or have $10 deducted from their payroll check for five (5) pay periods, etc.

Contact Payroll (City Hall Tower, 4th Floor, 535-7070) for examples of the various combinations of dollar amounts and time periods employees can select to make their bond purchase.

Savings Bond Enrollment

Employees may sign up for the Savings Bond program during normal business hours in the Payroll Office in the City Hall Tower, 4th Floor. Please allow for a two-week processing time. Contact Payroll at 535-7070 for any questions.